"BEING DIFFERENT"
AN ONTO-THEOLOGICAL APPROACH TO THE HUMAN PHENOMENON OF SPINAL CORD INJURY

A Dissertation

Presented to

the Faculty of the

School of Theology at Claremont

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

---

by

Wilson Edwin Daniel

June 1974

This dissertation, written by

WILSON EDWIN DANIEL

under the direction of his *Faculty Committee, and approved by its members, has been presented to and accepted by the Faculty of the School of Theology at Claremont in partial fulfillment of the requirements for the degree of*

DOCTOR OF PHILOSOPHY

Faculty Committee

Frank W. Kimper
Chairman

Howard Clinebell

Allen J. Moore

Hans Dieter Betz

Leonard [illegible] Rhoades

Date May 28, 1974

Joseph C. Hough, Jr.

PLEASE NOTE:

Several pages contain colored illustrations. Filmed in the best possible way.

UNIVERSITY MICROFILMS

MAY RUSSELL DANIEL

uxori carissimae meae

"Non scholae, sed vitae discimus"

Quintilian, *Institutio Oratoria*, x, 2.

ACKNOWLEDGMENTS

The study of man in all his vicissitudes is a never-ending process of self-discovery for the researcher. In exploring the nature and meaning of irreversible physical disability, with particular reference to spinal cord injury, the writer has become deeply aware of his own humanity not only in all its existential anxiety and finitude but also in its amazing capacity for compassion and hope, personal fulfillment and faith.

J. Frank Dobie (1888-1964) wrote: "the average doctoral thesis is nothing but a transference of bones from one graveyard to another." (A Texan in England, 1945.) The writer's experience has been very much the opposite. The bones have lived and the exercise, although exacting, has been stimulating, challenging and personally rewarding. Completion would not have been possible without the continuous, patient and loving support of my wife and daughters and also of my son in New Zealand.

For the help and encouragement of the Chairman and members of my Guidance Committee throughout this project, for the personal interest of Drs. Daniel J. Feldman, Herbert Johnson, Mr. Laban Strite and other members of Staff of Casa Colina Rehabilitation Center and for their kindness in making research facilities available, I am deeply grateful. I wish to thank Mesdames Dawn Peters and Barbara Henckel for their valued assistance in typing the manuscript and Mr. Richard Denton for proof-reading it. Finally, I express my admiration of and gratitude to those brave and wonderful people whose lives I have been

privileged to share in the course of this research and sojourn in the United States and who have enriched my own life immeasurably. They have taught me the meaning of true humanity and made Tillich's concept of the "courage to be" a daily reality.

TABLE OF CONTENTS

CHAPTER PAGE

PART II

CHAPTER PAGE

PART I

CHAPTER I

THE INVESTIGATIVE PROBLEM

1. INTRODUCTION

When man encounters directly through physical or other limitations, the threat of non-being whose ultimate expression is death, he can decide either to acknowledge or to deny his finitude. If he accepts his finitude he affirms his essential humanity and thereby allows others to minister to him. He will also feel accepted by, and in tune with, his Creator. This is a self-integrating, self-creating and self-transcending experience which can counteract the onset of feelings of meaninglessness, guilt and fate which so often accompany traumatic events.

A denial of his own finitude and of his interdependence with the rest of humanity will lead man into the abyss of isolation, despair and futile existence. This is a self-disintegrative, self-destructive and even self-profanizing experience which can threaten the very core of his being, the self, and which in extreme forms will result in pathology and perhaps suicide.

The primary task of the medical and mental health professions has been largely to strive for maximal functionality and wholeness of the individual person. This can be achieved readily through a creative approach to normal existential anxiety and an avoidance of its neurotic counterpart. Too often, however, scant attention has been paid to the

ontological substratum of existential anxiety which has spiritual meaning and value in human life and can be formulated in theological concepts. It is at this point that the contribution of pastoral care and counseling comes into specific focus within the total context of comprehensive rehabilitation of persons with spinal cord injury, who have been subjected to drastic change in their life situations.

2. STATEMENT OF THE PROBLEM

The core problem confronting irreversibly disabled persons and with which this dissertation seeks to grapple has been stated by an experienced physician as follows:

> The greatest danger a disabled man faces is not that he may lose his earning power, but that he may, in boredom, apathy and despair, *lose the awareness of his own worth and dignity*. The material phases of the problem, although not fully mastered, are at least well in hand. The time is come when, if the work is to be fruitful, we must reach towards those intangible values that give life meaning and savor--toward a concept of rehabilitation that recognizes that *man is, or is capable of becoming, a spiritual being*. In this lies his capacity to overcome almost any physical handicap.[1]

Such a statement implies that an essential ingredient in rehabilitation is the affirmation of one human being by another or others, whatever the respective roles and circumstances of each may be. But before a person can sense or understand his being affirmed by another, he must first accept the affirmation of himself by the other who conveys to him the message: "You matter to me." "You can accept

---

[1]Henry S. Talbot, "A Concept of Rehabilitation," *Rehabilitation Literature*, XXII:12 (December 1961), 358-364. [Emphasis added.]

yourself as you are." "You are worth something to yourself--even though you can no longer walk and perhaps will never walk again." From then on he can take responsibility for himself, his present and his future life which he must continue to live, not in isolation, but in relation to others. It is when he recognizes his essential humanity in common with all others and can accept others' acceptance of him as he is without pretense that he can rise above his physical limitations, which then become secondary.

3. STATEMENT OF THE PURPOSE

Spinal cord injury is a specific human phenomenon which is encountered within the general area of irreversible physical disability. Whether it originates from disease or some kind of accident it necessarily involves a cataclysmic change affecting the life-style and self-image of the person concerned.

The increasing incidence of this category of disability in modern human experience has necessitated an understanding of it on the part of medical practitioners, mental health professionals, clergymen and the general populace. In the United States an estimated 125,000 persons have survived spinal cord injuries and more than 10,000 are added to this population each year.

This dissertation will seek to investigate the phenomenological aspects of spinal cord injury primarily from the perspective of pastoral care and counseling within the scope of comprehensive rehabilitation of the irreversibly physically disabled. This will be done in order

to describe some of the ways in which the phenomenon is observed and experienced in that context by those engaged in ministering to disabled persons in and outside of a rehabilitation hospital setting.

Based on an onto-theological view of man and utilizing insights from the systematic theology of Paul Tillich the study will be illustrated by 'person-world' reviews (i.e. case-study interviews) of disabled persons who have been hospitalized at one time or another in Casa Colina Rehabilitation Center in Pomona, California. This will allow for the testing of the hypothesis advanced in the following section.

4. THE HYPOTHESIS

The foregoing statements lead to the hypothesis on which this study is founded:

> The person with spinal cord injury has an intensified awareness of his need to be loved (i.e. affirmed as a being of dignity and worth) and also an intensified awareness that he may not be loved. It is only as the essential message of the Christian Gospel is communicated to, and received by him and he becomes sensitized to it that he can summon the courage to face his disability realistically and to learn to live creatively as a person of faith, hope and love, enjoying adequate and satisfying interpersonal relationships.

This hypothesis as formulated rests on several presuppositions (inter alia) concerning the nature and being of man:

(a) Man as a self-conscious being is aware that he is limited by time, space, creaturely contingency and a possible loss of self-identity in the process of change. He has potentials which are always in tension with his limitations. For these reasons he has to deal constantly with his finitude.

(b) Man is a self-affirming being for whom the experiences of life must have meaning. He has inherent in him a "drive" towards consistency and a need for the increase of experience and its integration into his life.

(c) Throughout his life man experiences anxiety which he can use either constructively or destructively. As paradoxically both free and finite, man is inevitably anxious. His responses to anxiety may differ widely.

(d) Man in his being has a basic thrust towards relatedness with other selves. He is essentially interdependent. As an interpersonal creature, he can never be wholly self-sufficient. In disability, he may be either positively or negatively dependent on others.

(e) Man has the need and the possibility of participating as a centered being in other beings. He is created to love and to be loved, and loves for his own sake. He desires reunion and reestablishment of community with others, because that is the nature of his being. His true identity is found only in relationship.

(f) As man accepts from others the unconditional love of his being as a unique and worthful person, he is empowered and encouraged to risk actualization of his freedom within responsibility. To affirm

a human being with his disability is to acknowledge his freedom to be different.

(g) Man as a self-conscious being is able to stand outside or beyond himself and consider various aspects of his being. This self-transcendence distinguishes him from organic beings.

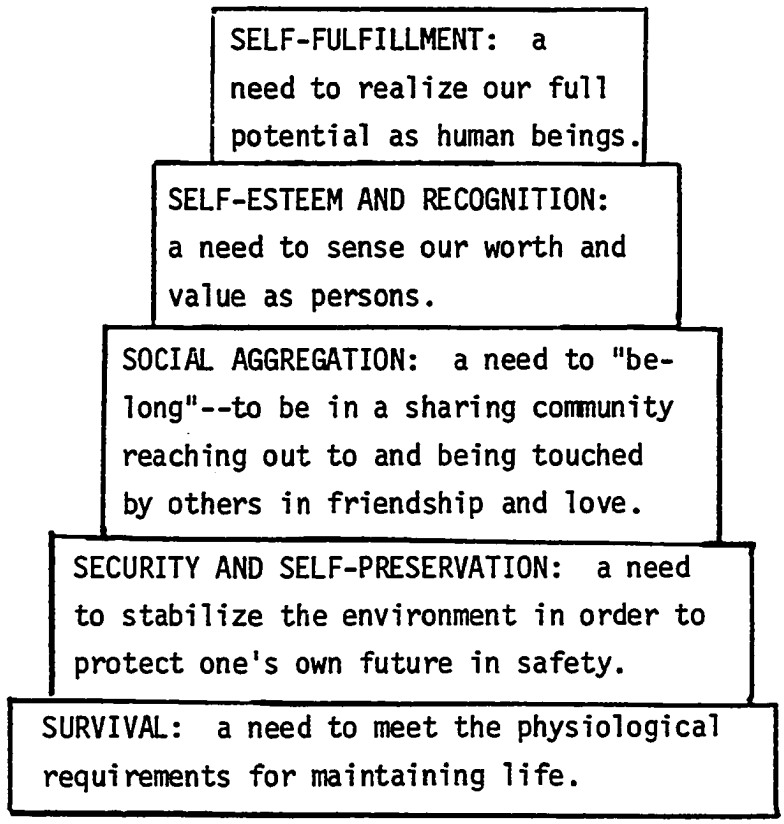
(h) Man is by nature basically a religious being in the sense that he is constantly in quest of meaning in life expressed in self-discovery, in relationships with others and with the Ground of his being. If alienated either in fact or in imagination from his fellows because of drastic change in his life situation, he seeks to be "bound back" into the mainstream of humanity.

(i) As a "religious" being, man is capable of examining and adopting or rejecting values and attitudes concerning his existence. He has freedom of choice to fulfill or to avoid fulfilling his potentialities.

(j) Man is known essentially in the person of Jesus of Nazareth as the Reconciler of men to God and man to man and as the Revealer of God, the Ground of Being, the Creator and Sustainer of life.

(k) One meaning and content of the Gospel or Good News of the Christian faith is embodied in the ministry of healing and caring to the irreversibly physically disabled. It can be communicated verbally and non-verbally, and both individually and collectively, through interpersonal relationships and has the power to elicit faith, hope and love in the person who receives its essential message.

Abraham Maslow[2] has developed a hierarchy of personal human needs which may be classified on five levels: physiological, safety, love and belongingness, esteem and self-actualization, in that order of precedence. The following pyramid is one representation of this hierarchy:



Initially, man's most pressing needs are at the bottom of the pyramid. This is especially so in the case of the spinal cord injury person. But once a lower need is satisfied, and the pressure of that need is relieved, the next higher need becomes the most urgent one.

---

[2]See Abraham H. Maslow, *Motivation and Personality* (New York: Harper & Bros., 1954), p. 9. It is submitted that in actual experience the categories of Self-Esteem and Recognition and Social Aggregation overlap and are closely interrelated.

Current shifts in value orientations correspond to the successful elimination of deep concern about the lower level needs for large numbers of persons so that the center of gravity of concern rises from the levels of survival and self-preservation to new levels of self-worth and meaning; from the physical to the psychological and spiritual. It is recognized that concern for survival and self-preservation is in itself an affirmation of self-worth.

Hadley Cantril[3] summarizes the main aspects of "human value" as follows:

1. man requires the satisfaction of his survival needs.
2. man wants security in both its physical and its psychological meaning to protect gains already made and to assure a beach-head from which further advances may be staged.
3. man craves sufficient order and certainty in his life to enable him to judge with fair accuracy what will or will not occur if he does or does not act in certain ways.
4. human beings continuously seek to enlarge the range and the quality of their satisfactions.
5. human beings are creatures of hope and are not genetically designed to resign themselves.
6. human beings have the capacity to make choices and desire to exercise this capacity.

---

[3]Hadley Cantril, "A Fresh Look at the Human Design" in James F. T. Bugental (ed.) *Challenges of Humanistic Psychology* (New York: McGraw Hill, 1967), pp. 14-17.

7. human beings require freedom to exercise the choices they are capable of making.
8. human beings want to experience their own identity and integrity.
9. human beings want to experience a sense of their own worthwhileness.
10. human beings seek some value or system of beliefs to which they can commit themselves.
11. human beings want a sense of surety and confidence that the society of which they are a part holds out a fair degree of hope that their aspirations will be fulfilled.

These aspects are especially applicable to the situation of the spinal cord injury person.

Howard J. Clinebell, Jr.[4] lists four basic spiritual needs which all men have, whether or not they are aware of them:

1. the need for a meaningful philosophy of life and a challenging object of self-investment.
2. the need for a sense of the numinous and transcendent.
3. the need for a deep experience of trustful relatedness to God, other people, and nature.
4. the need to fulfill the "image of God" within oneself by developing one's truest humanity through creativity, awareness and inward freedom.

---

[4]Howard J. Clinebell, Jr., "Counseling on Religious-Existential Problems" Chapter 14 in his *Basic Types of Pastoral Counseling* (Nashville: Abingdon Press, 1966), p. 251.

The above hypothesis and supporting presuppositions will be elucidated and tested as the study proceeds.

5. SIGNIFICANCE AND RATIONALE OF THE STUDY

Within the larger field of comprehensive rehabilitation of the irreversibly physically disabled, this dissertation is primarily a study of man in his humanity at its deepest level. With, and in spite of, his obvious physical limitations, man is regarded, not as a "disabled person," but rather as a "person with a disability."

Cataclysmic change, in the form of massive disability resulting from industrial, sporting, highway, or other accidents, chronic disease or war service, precipitates in man an "existential" crisis necessitating decisions concerning his present and future commitments and values and a definition of his humanity. It affects radically his self-image and life-style. This experience brings into prominence certain polarities of being based on theological and psychological concepts, namely, finitude and infinitude, good and evil, being and non-being, fate and destiny, wholeness and otherness, and so on. These must be reckoned with seriously in the physically disabled person's restoration-salvation as a maximally functioning human being who is worthwhile in his own eyes and in the sight of God and men. As the goal of rehabilitation is the maximal release of all the resources of the person with disability, his religious faith is often a powerful, crucial, and unique factor, which may be either positive or negative.

The medical and helping professions attempt, however inade-

quately, to approach man in his disability holistically, in all his human dimensions as a physical, emotional, social, and spiritual being, rather than fragmentarily, within the narrow confines of any specific disability or diagnosis. The current concept of comprehensive rehabilitation of the physically disabled assumes an inter-professional team approach on the part of the healing agencies, since no one profession can treat the whole person in all the dimensions of his life. Therefore the pastoral counselor is involved, along with the physician, surgeon, physical therapist, vocational counselor, nurse, psychologist, and social worker in the total rehabilitative process. Whether in the context of the hospital or rehabilitative center or of the church congregation through its outreach into the community, he is in a strategic position to minister to the person with disability and his family. But he must first obtain an understanding of the person and his world, which is the purpose of this project.

Within the multi-dimensional approach to the phenomenon in this study, theological insights will be used or criticized, wherever they are felt to be appropriate. Theology has given its answers to human suffering and physical and mental illness generally, but frequently the observations have been remote from the actuality of a particular condition such as spinal cord injury and without any clear or firsthand knowledge derived from any personal involvement.

Permanent physical disability is concerned with the dialectical relationship between a person and his world. There is a need, therefore, to understand the basic structures and needs of our human

existence so that we can see how physical disability affects these structures and needs. In our development as persons we are often involved in the enigmas of contradiction, paradox and even irrationality. In our anxiety we may be unable to discover a clear concept of the self or of what it means "to be." Uncertainty may mask our relationships, and the distortions of others near us may become our distortions. We become frightened and sensitive in our relationships. This may be followed by increasing feelings of inadequacy in our efforts to relate to our world. Man is, therefore, in a dilemma, caught between the basic thrust of his being towards relatedness with others, with the world and with the unfulfilled potentials within himself, on the one hand, and feelings of alienation and estrangement on the other. In the case of the person with spinal cord injury this feeling of separateness from others stems, as will be illustrated later, from the "differentness" of his condition and his way of coping with this either positively or negatively.

It must be stated that there is a considerable paucity of literature concerning this specific human phenomenon. Apart from occasional and isolated journal articles which deal almost exclusively with psychological, vocational or pastoral counseling approaches to other categories of irreversible physical disability, no serious attempt has been made previously (to this researcher's knowledge) to discuss and illustrate spinal cord injury in any extensive or integrative way.[5]

---

[5]One notable exception is Dan H. McEver, "Pastoral Care of the Spinal Cord Injury Patient," *Pastoral Psychology*, XXIII (February

In the course of this study reference will be made to two major works in the broad field of physical disability and general rehabilitation. Charles Palmer makes a valuable contribution in emphasizing the important place of religious factors, values, attitudes and beliefs and the roles of pastors and congregations in the rehabilitation of persons with disability in general, but his work lacks sufficient concrete case material.[6] Beatrice Wright concentrates on the nature and scope of general disability, adaptation to physical and social environment, sexual, marital and family adjustment, behavioral modifications, value changes, development of self-concept and rehabilitative treatment theories.[7] Religious or spiritual dimensions of physical disability are not discussed.[8]

A research project, the essential content of which is perhaps the closest approximation to the focus of this dissertation, was a

---

1972), which will be referred to in Chapter III, p. 106.

Relevant articles which deal in a more general way with the broad scope of irreversible physical disability include the following: *Pastoral Psychology* (June 1965), entire issue, entitled "The Church and the Physically Handicapped"; E. V. Stein, "The Role of the Clergy in Catastrophic Illness," *Journal of Pastoral Care*, XX (March 1966); Daniel J. Feldman, "Beyond Disease" (unpublished monograph, 1970--a comprehensive biosocial view of physical disability).

[6]Charles E. Palmer, *Religion and Rehabilitation* (Springfield, IL: Thomas, 1968).

[7]Beatrice A. Wright, *Physical Disability* (New York: Harper & Row, 1960).

[8]A more recent work is that of James W. McDaniel, *Physical Disability and Human Behavior* (New York: Permagon Press, 1969) which evaluates critically the psychological effects of chronic illness and physical disability and their influence on human behavior as a factor in the rehabilitative process.

study in 1962 and 1963 by Jack E. Briersdorf and John R. Johnson, Jr., of religious attitudes among disabled patients in two rehabilitation hospitals in New York City. A survey of 98 persons was conducted on an open-ended, one hour-long interview basis. The report of that study was contained in a short article.[9] This dealt with changes in the content and significance but not the structure and intensity of a person's faith under the impact of traumatic physical disability. The study was supported by limited case material and was never revised or published.

This present study differs from all the above and is of value in that its distinctive focus is on the discussion of the onto-theological approach to human existence and love as an essential and preliminary basis from which to observe and illustrate the specific human phenomenon of spinal cord injury within the scope of empirical research.

Building upon the foundations laid by the limited amount of literature which exists, this dissertation will attempt to expand and integrate rather than duplicate what has been written already. It will seek to formulate and expound a conceptual framework based on philosophical and theological construction, which is considered by the researcher to be indispensible to a proper understanding of the phenomenon of spinal cord injury. It is hoped that this approach will

---

[9]Jack E. Briersdorf and John R. Johnson, Jr., "Religion and Physical Disability," *Rehabilitation Record*, VII:1 (1966), 1-4. This was reprinted in Palmer, as an Appendix entitled "Religious Factors in Physical Disability and Rehabilitation."

be a means of reinforcing pastoral care and counseling and general psychotherapeutic procedure which the researcher believes is integral with, rather than ancillary to, medical treatment and psychological and vocational testing.

This project is also intended to fill, at least in part, some of the gaps in the present literature and practice in this area, and without presuming to be anything in the way of a definitive work, to lead to a more informed and effective ministry by the church and its pastors and members to this increasingly large segment of population in modern society.

6. DEFINITION OF TERMS AND LIMITATIONS

"Disability" throughout this dissertation refers to a specific medical condition of physical impairment, viz. spinal cord injury, which has an objective aspect which can usually be described by a physician. One of the classic features of the condition is its irreversibility. For this reason it is referred to interchangeably throughout this project as "irreversible," "permanent" or "massive."

It is caused by disease or traumatic accident resulting in disturbance of structure and organic function from which two main and important consequences flow:

(a) a reduction or loss of the individual's ability to cope with his environment.

(b) a deterioration of the individual's ability to function within his social milieu, i.e., an incapacity to live and work within

his family, place of employment and community in the same way as before his disability.

These two factors, along with disease or abnormality arising from congenital defect generally operate in any given case of illness. The description 'physical disability' has been chosen purposely in preference to the older and looser connotation 'body handicap.' 'Handicap' has been distinguished from disability by Hamilton as "the cumulative result of the obstacles which disability interposes between the individual and his maximal functioning level."[10] Thus, 'handicap' refers more closely to what has been called a somatopsychological relation, a relation dealing with variations in physique which affect a person's psychological situation by influencing the effectiveness of his body as a tool for actions or by serving as a stimulus to himself and others. This, in turn, must be distinguished from the psychosomatic relation, i.e. the relationship between a person's emotional and mental attributes and his predisposition towards certain types of organic dysfunction. As problems, these two relations differ conceptually and are not dealt with within the scope of this study.

Not all conditions which may be classified medically as disabilities are perceived as handicaps. This is because the determination of maximal functional level, or what a person needs or is expected to do, depends partly on the cultural setting in which he lives. Again, a handicap must always be assessed in terms of the requirements of the

---

[10]K. W. Hamilton, *Counseling the Handicapped in the Rehabilitation Process* (New York: Ronald Press, 1950).

situation in which a person finds himself.

Similarly, even severe disabilities need not amount to major handicaps, e.g., a paraplegic whose job does not demand quick locomotion may find his wheelchair no more frustrating than a train or bus ride is to the person who assumes unquestioningly that he must travel daily to work by such transport. Conversely, a person may feel handicapped physically, even though from medical diagnosis his physical limitations are not disabilities. In this respect, a person who aspires to become a famous singer, despite being endowed with only an average voice, is handicapped in the sense that his physical characteristics hinder his progress towards his goal. His maximal functional level is insufficient to meet the actual functional level demanded by his aspirations.

In summary, disability may be regarded as a biological phenomenon in which an individual's coping mechanisms are interfered with seriously and his competence to negotiate his environment is compromised.

'Comprehensive Rehabilitation' as used in this study is the concept of a multi- and inter-disciplinary approach to the life situation, including life-style and function of an irreversibly physically disabled person. As will be amplified later, it seeks to minister to such a person in every dimension of his existence, to confirm his value as a human being to the fullest extent and to be concerned with the meaning and quality of life. Rehabilitation Medicine or Medical Rehabilitation in this context is concerned primarily with the diagnosis and treatment of physical disability as a significant component

of illness. It is responsible for recognizing and identifying the disability and the extent to which it has diminished the person's capacity to cope with his environment. The primary focus and skill of medical rehabilitation is on the consequences rather than the causes of the physical alteration, although the importance of the prognosis is not overlooked. To this end, it is concerned with minimizing the functional restrictions of disability through physical restoration as far as possible, recognition and management of emotional and behavioral concomitants, and the preparation of a suitable environment. Because these three processes together may affect the functional ability of the person with disability, they are pursued concurrently and not in defined succession.

"Identity" (self-image) refers to a person's definition of his selfhood. Following Erikson, it is the continuing "I" as seen as "the center of awareness in a universe of experience in which I have a coherent identity and . . . am in possession of my wits and able to say what I see and what I think."[11] Identity focuses on internal dynamics in the person-world reviews in this study and is elaborated in terms of inner, covert behavior, e.g. feelings, perceptions, attitudes.

"Life-Style" concerns those activities in which a person chooses to engage as an expression of his identity. It refers to the form or acts of behavior through which people live their lives. Life-

---

[11]Erik H. Erikson, *Identity* (New York: Norton, 1968), p. 220.

styles may be viewed not only as personal and individualistic but also as relational. This study assumes that life patterns are fluid and progressive. Through the interviews an attempt is made to highlight segments of the developmental process, sampling styles representative of spinal cord injury persons as an identifiable group in society. Life-style focuses on external dynamics and is elaborated in terms of observable, overt behavior, e.g. recreational and religious activities, etc.

7. RESEARCH DESIGN AND METHODOLOGY

Adopting the approach of phenomenological psychology and existential philosophy, the dissertation will proceed by way of investigation and analysis of selected cases of irreversibly physically disabled persons who have sustained spinal cord injury.

The justification for this methodology is grounded in a focus upon the existential situation of the person with physical disability which demands an understanding of the individual human being and his *Lebenswelt*. The pastoral counselor, in addition to fulfilling the primary task of ministering to persons in need, is enabled to conduct research through observation of, and interaction with, such persons. In this he can strike a balance between subjectivity and objectivity by involving himself personally in the *Sitz-im-leben* of a disabled individual as it is perceived, experienced, and responded to by that individual. Existentialism asserts that each person must seek self-actualization within the reality of his own life situation.

Certain aspects of humanness defy exhaustive definition and measurement, so that absolute objectivity is not possible in the sphere of the study of man. In any case, objectivity is relative in any context. Nevertheless, the pastoral counselor, on the basis of trust, can relate to a person with disability as a living "human document" in Anton Boisen's reference in such a way that through subjective interaction the person can be observed and described phenomenologically.[12]

Unfortunately, the term "research" sometimes suggests an impersonal approach. At other times "research" is assumed to involve automatically complicated statistical machinery and procedures and elaborate quantitative measuring devices. Even the word "scientific" carries these unfortunate connotations. At the interface of theology and psychology and the social sciences there is room for the recognition of "scientific" as including descriptive, ideographic, and personal approaches in addition to purely quantitative, nomothetic, and objective considerations. Basically a "scientific" approach or method incorporates anything and everything which contributes to the advance of human knowledge.

The method of research which is used here is one way in which each unique individual can be regarded seriously as a total human being and not a thing, animal, theory, or statistic. Therefore, it (honestly and without apology) accepts the subjectivity involved in

---

[12]Anton T. Boisen, *The Exploration of the Inner World* (New York: Harper & Row, 1936).

the research, without feeling under pressure to eliminate the subjective factor in favor of the objective or in order to preserve "purity."

The phenomenological approach already mentioned is epitomized by B. F. Nel in his comment that persons

> . . . should be viewed in terms of specific situations in the world. The [person] should be seen as an existential being in the process of realizing himself within a particular situation. An analysis should be made of the particular way in which [this person] encounters the world he lives in.[13]

A further dimension of this research method is the recognition that each person with disability endows the objects and events of the world with meaning which can be understood and responded to by others. From his research with alcoholics, Roy Woodruff summarizes this function:

> Effective pastoral research not only collects data; it also performs a ministry of concerned listening to and participating in the life of the individual. The pastoral researcher should endeavor to form a faithful friendship with the respondent, taking seriously his developmental pilgrimage, and giving him encouragement in his present circumstances.[14]

The essential ingredient of this approach is that persons with disability, as they are regarded seriously by the pastoral counselor as a "participant-observer-researcher" begin to feel like participants themselves. In effect, they become teachers as they introduce the pastoral counselor into their life situation, involving interpersonal

---

[13]Barend F. Nel, *A Phenomenological Approach to the Problems of Youth* (Pretoria, South Africa: University of Pretoria Press, 1960), p. 6.

[14]C. Roy Woodruff, *Alcoholism and Christian Experience* (Philadelphia: Westminster Press, 1968), pp. 128-29.

and intra-family relationships.

Firm precedents and models for the case study methodology and phenomenological approach exist in the writings of Sigmund Freud and Carl Jung based on interviews in busy medical practices and in the works of Harry Stack Sullivan[15] and Ludwig Binswanger.[16] More recently R. D. Laing[17] and E. Kübler-Ross[18] have used these methods to good effect. In addition, Anton Boisen, as a chaplain, described his work with mentally ill persons and the knowledge he gained.[19] In the post-World War II period, Roy Grinker and John Spiegel illustrated their pioneer book on psychiatry from carefully collected records of emotional problems faced by troops in actual combat conditions.[20] In the same period, Michihiko Hachiya chronicled his medical work in *Hiroshima Diary* with victims of the atomic disaster.[21]

---

[15]For the term "participant-observer" see Harry Stack Sullivan, *The Psychiatric Interview* (New York: Norton, 1954), pp. 19-25.

[16]See the cases of Ellen West and Ilse in Rollo May, *Existence* (New York: Simon & Schuster, 1958), pp. 219, 237.

[17]R. D. Laing, *The Politics of Experience* (New York: Pantheon, 1967).

[18]E. Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1969).

[19]Boisen.

[20]Roy R. Grinker and John P. Spiegel, *Men Under Stress* (Philadelphia: Blackeston, 1945).

[21]Michihiko Hachiya, *Hiroshima Diary* (Chapel Hill: University of North Carolina Press, 1955).

A further validation of the type of descriptive research to be employed in this dissertation is found in the methodology of case study formulated by Hill and Kerber which "describes and interprets all pertinent data from a particular case or limited number of cases . . . and provides greater depth to the research."[22] These authors suggest by their inclusion of the case-study method that this is a legitimate and fully acceptable kind of descriptive research.

Gordon Allport[23] recognizes the "patterned individuality" of each human being in the sense that because each person is unique, the researcher can learn something slightly different from each one. Robert W. White reinforces this view when he writes: "The study of personality is in part the study of individual differences . . . in temperament and ability."[24] Although general understandings and conclusions can be extracted from investigations and observations, the unique responses to life that make up individual life-styles are the most basic ingredient. Elsewhere, Allport[25] adopts an ideographic view and distinguishes this from nomothetic research. The ideographic

---

[22]Joseph E. Hill and August Kerber, *Models, Methods and Analytical Procedures in Education Research* (Detroit: Wayne State University Press, 1967), pp. 108-09.

[23]Gordon W. Allport, *Pattern and Growth in Personality* (New York: Holt, Rinehart and Winston, 1961), pp. 3-21.

[24]Robert W. White, *Lives in Progress* (New York: Holt, Rinehart and Winston, 1966), p. 7.

[25]Gordon W. Allport, *The Use of Personal Documents in Psychological Science* (New York: Science Research Council, 1942), pp. 53-57.

approach concerns generalizations based on a single life studied in depth, whereas nomothetic research refers to statistically reliable general principles drawn from a large collection of data from individual lives. In acknowledging that the most rigid tests of scientific procedure are those of understanding, prediction, and control, Allport nevertheless asserts that such tests can be based on a single life as well as a number of lives.

An essential characteristic of this kind of research is the personal aspect and quality. Carl Rogers, whose "client-centered therapy" is analogous in some respect to Anton Boisen's concept of persons as living "human documents"[26] to be related to, rather than as objects to be manipulated, differentiates between two scientific modes of psychological research. The strictly objective approach is "non-human, impersonal, rationally based on knowledge of animal learning," while the subjective approach constitutes a "humanistic personal encounter in which concern is with an 'existing, becoming, emerging, experiencing being.'"[27]

The emphasis of the subjective approach is upon the special human characteristics of both counselor and counselee in addition to

---

[26]Boisen's studies involved a warm, human approach by chaplains to mentally disturbed hospital patients whom the general public often regarded as almost sub-human; but even there the focus was primarily on an understanding of the person himself and secondarily on the interactional process between the patient and the chaplain.

[27]Carl Rogers, "Two Divergent Trends," in Rollo May (ed.) *Existential Psychology* (New York: Random House, 1961), pp. 89-92.

the actual therapeutic encounter between the two, i.e., in the context of this dissertation, of the researcher and the person with spinal cord injury. The ideographic approach presupposes each person's uniqueness as an essential human characteristic for study purposes. Wilson van Dusen in an article, "The Natural Depth in Man,"[28] describes validity in science over against validity in humanism. Scientific validity is what can be commonly agreed upon because science discovers the common in the varied. Humanistic validity is determined in the final analysis by the subject himself, because humanistic phenomenology finds the varied in the common.

In order to avoid any suggestion of a strictly clinical orientation and also to stress the descriptive nature and quality of this research, the term person-world review has been selected in preference to that of case study or case history. This description emphasizes the researcher's primary concern with the person's subjective experience and the dynamics at work between the researcher and the person in the interview, all of which produce an experiential environment for the researcher. The disadvantages and shortcomings of the older case study or case history method consisted mainly in that, while as much background data as possible about an individual person was collected in order to understand him[29] and from that to reconstruct the world of

---

[28]Wilson van Dusen, "The Natural Depth in Man," in Carl R. Rogers and Barry Stevens (eds.) *Person to Person: The Problem of Being Human* (Walnut Creek, CA: Real People Press, 1967), p. 214.

[29]See Benjamin Kleinmuntz, *Personality Measurement* (Homewood, IL: Dorsey Press, 1967), p. 160.

his subjective experience from his unique frame of reference, this often completely overlooked the interactional process between the person and the researcher. The person-world review adopted here is grounded in the recognition by existentialist phenomenology of the person-in-his-world or "being in the world."

In this respect, this researcher has been influenced by the existential analysis of Ludwig Binswanger who accepts Martin Heidegger's ontology (*Dasein*) which asserts that man is "thrown" (*geworfen*) into the world without decision or choice. Man-and-his-world form an entity and this unity of existence renders vain any attempt to study man-in-isolation or to reduce him to an object of observation. Man's experience of being is characterized by a quality of "mineness" (*Jemeinigkeit*) which is not always acknowledged and which is constantly threatened by depersonalization and submergence in the anonymous collective (*das Man*). And so man's being is marked by its fallenness, making him fearful and anxious.

Two modes of being-in-the-world are open to him: the authentic and the inauthentic. To some extent his being is always inauthentic in that he is constantly under the sway of *das Man*, and that his being is characterized by the ambiguity and curiosity and even irrationality that confuses authenticity with inauthenticity. He is prone to avoid the meaning of being, to capitulate in despair, and to negate the reality of his own death, either by postponing it in time or by restricting the possibilities of death to other people.

Nevertheless, there is the possibility of authentic being.

Authenticity involves man in accepting his possibilities and in making a decision. Basically, the possibility which is uniquely mine is my own death.

"If I am cast into the world, it is in order to die there."[30] Man realizes his authentic being when he stands apart from the crowd and confronts his own death as his most personal possibility. Lost in inauthenticity, man's conscience summons him. As it calls, he discovers he is guilty--guilty of his inauthenticity. In order to overcome his despair, he must deal with it as he must deal with his death--recognize it and shoulder it with frankness and determination.

Binswanger, while adopting contributions from Martin Buber's I-Thou, I-It relations, also accepts Heidegger's ontology, but finds it necessary to add to it some further concepts of his own comprising three *Weltmoden* of personal existence which have appropriate application to the phenomenon of spinal cord injury under discussion. 1) *Umwelt* includes all the events in the biological or natural world, excluding other human beings, i.e. the environment as it acts on our drives, instincts, needs. 2) *Mitwelt* includes other people and their behavior towards the individual, i.e. inter-relationships. 3) *Eigenwelt* includes all of the individual's own behavior to which he may respond, i.e. the self-awareness and self-reference which are the basis on which persons relate to the world. In addition, there is

---

[30] R. Grimsley, *Existentialist Thought* (Cardiff: University of Wales Press, 1955), p. 63.

Fateworld which includes all events over which the individual has no control.[31]

Since man is aware of himself he is believed to have the innate potential to be aware of his own behavior and the context in which it occurs. He therefore chooses various alternative courses of action which make him responsible for his behavior. Although this behavior is occurring constantly, it is not at random but is always related to surrounding events which are placed in the *Weltmoden* described above. Each person develops habitual ways of relating to these various kinds of events, viz: (1) *Being-at-hand*--relating to the natural world or environment (*Umwelt*). (2) *Being-with-others*--relating to other people (*Mitwelt*). (3) *Being-in-itself*--relating to oneself (*Eigenwelt*). (4) *Being-beyond-the-self*--relating to abstract attributes of events or of transcending immediate physical events (*Fateworld*).

For Binswanger, man's relationships with his fellow human beings are considered to be of the utmost importance. Love, i.e. being-allowed-to-be is central. And so the following existential modes or ways of relating to other persons are used: 1) *Anonymous:* in the collective--relating to others without knowledge of who others are and vice versa. 2) *Singular:* all of man's relationships with himself as a person to whom he may respond, evaluate and identify. 3) *Plural:* formal--all self-centered relationships between two

---

[31]For a full explanation and discussion see May, *Existence*, pp. 55-65.

people, in which there is no personal concern and positive affection for the other person. 4) *Dual:* the extension of the I-Thou relationship--intimate, warm, or close relationships in which each person has a strong and permanent affection toward the other.

The above concepts have been developed to deal with the various ways in which an individual may respond to his environment and are appropriate to this study of persons with spinal cord injury in their experience of being and becoming, non-being and existential anxiety.[32]

In adopting the person-world approach to the collection of research data, this researcher assumes that the interview *per se* will elicit data on important aspects of the person and his chosen means of coping. This is in line with the rationale underlying several psychotherapeutic approaches which maintain that behavior is significant and provides clues to a person's internal frame of reference and also to his world. It was Harry Stack Sullivan, who in the creation of the term "interpersonal" made the client-therapist interaction crucial in the entire therapeutic process. With this in mind, the person-world review recognizes and employs two interacting factors: first, the person, whose nature and being cannot be understood apart from his relationships with other humans who become a part of his world; and secondly, the interaction of other persons with him, i.e. also the world, represented by the researcher himself.

---

[32]See Julian M. Nadolsky, "Diagnosis in Rehabilitation Counseling--An Existential Approach," *Rehabilitation Literature*, XXVII:3 (March 1966), 66f.

Since Sullivan's time, both Erik Erikson[33] and Kenneth Keniston[34] have recognized fully the importance in humanistic research of understanding not simply the intra-psychic phenomenon of the individual but also the context of the interviewer and his intra-psychic world, the context of the community as it observes both the interviewer and the subject, and the place in history of all the persons and communities involved. In a real and novel way, the recorder-researcher is not entering the other person's life history or world merely to record it, but he is also making actual history at the same time. Keniston has indicated that personal, subjective involvement in his research was indispensable for a proper understanding of the persons interviewed and for experiencing their worlds. He asserts that there is no such thing as total objectivity. The researcher is virtually his own microscope, and his reactions to a person in an interview form a major portion of the gathered data.

Sampling of Persons for Study

For the descriptive research contained in this dissertation, in-depth interviews of two hours' duration were held individually with twelve[35] persons with spinal cord injury of both sexes, and the

---

[33]Erik H. Erikson, *Young Man Luther* (New York: Norton, 1958); Erik H. Erikson, *Gandhi's Truth* (New York: Norton, 1969).

[34]Kenneth Keniston, *The Young Radicals* (New York: Harcourt, Brace & World, 1968), especially Appendix A, pp. 291-96.

[35]Beatrice A. Wright, *Physical Disability* (New York: Harper & Row, 1960), uses data from eight case studies throughout her work.

information gained has been used solely to describe and illustrate the perceptual and experiential aspects of the phenomenon being investigated.

Locale and Agency

The locale of the sample was confined to the San Gabriel, Pomona and San Bernardino valleys in which the interviewees were resident. A representative selection was made from both in-patients (or "residents") and out-patients at Casa Colina Rehabilitation Center, Pomona, California,[36] with whom the researcher had a counseling or pastoral relationship extending, in some instances, for up to two years. Casa Colina treats, in addition to spinal cord injury, a variety of categories of irreversible physical disability including muscular dystrophy, rheumatoid arthritis, multiple sclerosis, etc., and has initiated stroke re-socialization and volunteer support programs in neighboring communities. Throughout the period of research the writer had the full encouragement and support of the clinical director and other staff members including psychologists, physiatrists, psychiatric consultants, visiting physicians and surgeons, nurses, therapists, vocational counselors, social workers and administrative assistants.

Case histories, diagnoses and treatment plans, etc., were made available whenever required and the researcher had full and

---

[36]Two of the interviewees had also been hospitalized at the Regional Spinal Cord Injury Rehabilitation Center of Rancho Los Amigos Hospital, Downey, California.

regular opportunities for consultation with the staff of the center.

Selection and Criteria

No specific criteria were used as a basis for selection apart from the following:

(a) Each person expressed genuine interest in the interview and study for research purposes and volunteered information readily.

(b) Each person was willing to set aside time for the interview.

(c) Each person had been hospitalized for varying periods in both the acute and rehabilitative phases and in that time had been required to build up self-confidence, make decisions and develop trust in others.

(d) Each person was known personally to the interviewer outside the context of the interview and study. This minimized the possibility of giving answers to a stranger merely to impress and also enabled the interviewee to describe his life-situation openly, including all his hopes, aspirations and apprehensions.

Safeguards

The absence of a control group in this project could well give rise to the criticism of "interviewer bias" on the part of the researcher for there is no way to gauge the extent to which he may have caused biased reporting, however conscientiously and genuinely he tried to avoid this. The critics could suggest that the author more than his subjects was responsible for the emerging data. It is

admitted that no sufficient defense against such an accusation can be maintained.

Despite this apparent deficiency, certain safeguards were adopted. These included, for instance, the administration of the Self-Insight Questionnaire to spouses, and friends of the interviewees and professional staff who had worked with them in the rehabilitative process. This ensured the provision of supplementary data: the results were rated separately for the purpose of comparison. It is doubtful if a control group of itself, even if formed of members of another category of irreversible physical disability, would have enhanced the response validity of the research to any marked degree. The introduction of additional variables would have necessitated a different style of interview format which in turn would have affected the directness and value of the research.

Sociological Data

Of the twelve persons with spinal cord injury chosen three were women and nine were men. Their ages ranged from 20 to 39 with the median age at 27. Physical disability resulted from several causes including automobile and sporting accidents (diving and surfing), gun-shot wound, fall from horse-riding, one Vietnam war combat injury, and an industrial accident (fall from three-story building). Categorized as to disability, six were quadriplegics (including one woman) while the remaining six were paraplegics. All, with the exception of one woman, had received full or partial high school education, and eight

had proceeded to college and beyond. Most of the interviewees had migrated to California from other parts of the U.S.A., came from middle-class suburban families and represented a variety of vocational interests . . . a liaison officer at a rehabilitation center, a horse trainer, a service station employee, a carpenter turned student-in-training to become a minister of religion, an accountant, a housewife, a director of student services, a business executive and four university students. Only one, a black man, was a member of a minority group. Of the twelve, six were married (in one case both spouses had had previous divorces) and six were single. Each of the married interviewees was the parent of one or more children. In only one instance had the issue of separation and divorce been raised since the onset of disability, but no subsequent action had been taken. Each of the unmarried interviewees had moved out of his or her parents' home within a reasonable time after discharge from the rehabilitation center and had established an independent household, usually in an apartment with a paid attendant of the same sex (except in one case) on a part-time basis. Only one of the singles was hospitalized at the time of interviewing. In religious orientation there were two Jews, seven Protestants, one Roman Catholic, one Greek Orthodox and an agnostic.

To preserve the essential focus of the study no attempt at evaluation, correlation or scientific measurement in the usual sense was made. For the sake of convenience, manageability and consistency, and to avoid the possibility of contamination, the project was confined to an investigation of the category of massive physical disability

known as spinal cord injury resulting in paraplegia, tetraplegia or quadriplegia. It is submitted that this category exhibits comprehensively and to a marked degree the characteristics and dimensions of the human phenomenon under consideration.

Data Collection and Reporting

Various methods have been employed for obtaining the descriptive data required for the person-world reviews. These included the presentation of a semi-structured interview questionnaire, the completion of a supplementary Religious Inventory and Values Questionnaire and the administration of a Self-Insight Questionnaire.

The primary source of data-gathering, the semi-structured interview format, was selected because it afforded the best means of discovering and assessing, in a relaxed and conversational atmosphere, the feelings, attitudes and frame of reference of the interviewee concerning the discussion topics. The major aim of the researcher was to enter as fully as possible into the interviewee's world of relationships and feelings from his perspective, and on a person-to-person, informal basis.[37] The flexibility of structure permitted the full coverage of relevant questions under the various topics, leaving room for variation in sequence as the conversation proceeded.

The subject matters covered in the interview questionnaire

---

[37] Kleinmuntz, pp. 145, 149 suggests that the unstructured interview between two persons offers greater freedom to explore and identify general problem areas.

were broadly similar to those contained in the psychiatric case presentation form used by staff members of the Claremont Area Pastoral Counseling Center in their weekly case presentations before a consulting psychiatrist. The questions were divided into two main categories, viz. self-concept (identity) and life-style, and were aimed at probing the factors of change through the various *Weltmoden* of the individual interviewees. The topics were adapted in this dissertation to satisfy the requirements of the focus on spinal cord injury as a specific category of irreversible physical disability.[38] Much of the basic identifying data (especially demographic detail) had been obtained prior to each interview from medical case files and was merely brought up to date. In gathering information concerning personal growth and relationships within the interview there is an implicit assumption that the present personality of the person with disability is part of a continuing process of development. He alone is able to reveal to the interviewer the special interactions and components of this process. The interview questions were of the open-ended variety, designed to ascertain the interviewee's intensity of feelings, attitudes and frame of reference. They were formulated along the lines recommended by Kahn and Cannell, who stress the importance of pre-testing the interview schedule and suggest the use of the funnel approach to question composition and the sequence of presentation.[39]

---

[38]For the Interview Questionnaire see Appendix A, p. 230.

[39]Robert L. Kahn and Charles F. Cannell, "Interviewing" in Gardner Lindsey and Elliott Aronson (eds.) *Handbook of Social Psychology*

Presentation of the original schedule was made at Casa Colina Rehabilitation Center involving two patients. Subsequent adaptation of the schedule itself and reduction in the number of questions was found to be necessary, as these tended to produce only brief affirmative or negative answers or elicited some biased or conditioned statements which inhibited free and open responses. The main areas covered included self-concept, interpersonal relationships as a single or married person, perception of values, religious faith, views on rehabilitation, adjustment to the post-hospitalization stage and to socialization in the community, vocational motivation and future plans and societal attitudes towards disability. The aim was to explore the person's own perception of what areas in his life afforded the maximum or minimum confirmation of his worth as a human being.

The first stage in the data collection process was the tape-recorded interview (subsequently transcribed) which focused primarily on the person's own present experience of his disability in comparison with his pre-morbid condition and also in relation to his future orientation as a maximally functioning individual. As far as possible the information obtained was based on an interviewing and diagnostic procedure in rehabilitation counseling developed by Julian M. Nadolsky.[40] This adopts an existential approach whereby understanding entails more than just knowing factual details about the person being interviewed.

(Reading, MA: Addison-Wesley, 1968). Also Robert L. Kahn and Charles F. Cannell, *The Dynamics of Interviewing* (New York: Wiley, 1957).

[40]Nadolsky, pp. 66-75.

The interviewer must genuinely get to know the person. He must get at the inner, personal aspects of the person, his thoughts and feelings and how they influence, and are influenced by, the overt responses of himself and others. He must also discover how the person relates to himself, to other people and his environment. In the process the interviewer learns to relate to the person in a way which does not elicit anxiety and which helps the person to respond actively towards him. This can be a means of discovering and understanding his existence in an effort to help him establish well-balanced modes of "being-in-the-world."

The second section of the data-gathering format included, for the purpose of clarification and expansion in two main areas the completion of (a) a Religious Inventory designed to determine in some measure the content and intensity of the religious faith of a person with spinal cord injury in the light of his disability, and (b) a Values Questionnaire designed to ascertain the nature and extent of the interviewee's commitment, through the process of adjustment to his disability or through value change, to a positive reason for living.[41] A description of overall findings will be reported without the presentation of statistical tables in Chapter V.

In addition some excerpts of the analyzed data from the audio-taped interviews have been included within the text of the dissertation

---

[41]A copy of the Religious Inventory with notation of results can be found in Appendix B, p. 233. A copy of the Values Questionnaire together with sample graphs of results can be found in Appendix C, p. 236.

in the normal psychotherapeutic person-world review (i.e. "case-study") format for purely descriptive and non-evaluative purposes. The data have been used to substantiate and support, but not to prove conclusively, the major hypothesis advanced and to draw conclusions concerning the phenomenon being studied and the resultant implications for pastoral care and counseling.

The third and final portion of the format comprised the administration of a thirty-one item bipolar personality-traits inventory called a Self-Insight Questionnaire developed by Douglas Heath of Haverford College for measuring emotional maturity in young adults.[42] Of Heath's original thirty bipolar items, only twenty-seven were chosen, with four new ones added in different sequence to make up the full number of scales. These items were selected for their suitability to describe in terms of emotional growth the several polar elements implied in Tillich's ontological polarities of individualization and participation, dynamics and form, and freedom and destiny to be described in Chapter II.[43] The terms maturity or immaturity often

---

[42]His original questionnaire can be found in Douglas H. Heath, *Exploration of Maturity* (New York: Appleton-Century-Crofts, 1965), pp. 114ff. The researcher had previously had experience with this instrument in a research project under the direction of Howard J. Clinebell, Jr., of the School of Theology at Claremont, California, entitled "Training Clergymen to Train Laymen for Caring and Social Action Ministries," *Explorations in Ministry*, an IDOC Dossier, IDOC, North America, 1971, pp. 57-67.

[43]A copy of this "Self-Insight Questionnaire" together with sample score graphs of results can be found in Appendix D, p. 241f. The four additional bipolar traits introduced by the researcher are numbers 11, 12, 17 and 26.

precipitate evaluative responses which tend to prejudice the results and intensify a desire in the interviewee to respond positively to those items considered to measure socially desirable personality traits. For this reason, no reference has been made to these terms, and the title, Self-Insight Questionnaire, has been preserved on purpose in lieu of them in order that the results could reflect the interviewee's present self-perception and the present perception of him by others.

Accuracy was obtained between the rated individual's self-perception and others' perception of him through three separate SIQ scores for each person; viz. the first from the SIQ completed by the interviewee; the second from the SIQ given to a significant other, e.g. husband or wife or a chosen friend; and the third completed by a professional rehabilitation staff member or other professional person.

In order to plot the results of the SIQ administration and show an emotional maturity profile of the person, a graph was drawn placing one polar trait with positive value on the upper side of the graph and placing the opposite trait denoting a more negative value on the lower side. In the case of some traits, it was more desirable to strike a balance, particularly concerning item 11 (stubborn-compliant) where there is a need for self-confidence without conformity; item 19 (dependent-independent) where interdependent is the ideal; and item 20 (cautious-adventurous) where "adventurousness" in the case of a person with physical disability could indicate foolishness and therefore immaturity instead of maturity. Heath's criteria for maturity

and immaturity were used to determine the positive and negative values of the traits.[44]

To summarize, it is emphasized once again that the instruments just outlined and used in this study are intended for descriptive purposes only, and not as quantitative substantiation of the hypotheses advanced. The justification for the use of such person-world review materials has already been supported by Franklin C. Schontz.[45]

Summary

From this point on the dissertation will proceed as follows: Chapter II will focus on the nature of being and human existence using Paul Tillich's method of correlation and with particular reference to the ontological polarities and their disunity, the problem of human finitude, the types of anxiety and the meaning of acceptance.

It will also deal with the onto-theological understanding of man and will review and describe the life processes with specific application to Douglas Heath's psychological categories of maturity. It will conclude with a discussion of Tillich's ontology of love and

---

[44]See Heath, p. 135f. where qualities associated with maturity include (inter alia) enthusiastic, energetic, purposeful, goal-directed, well-organized, decisive, ambitious, honest, stable, responsible, independent, emotionally involved with others, fulfilled potential, flexible, predictable, etc., whereas qualities regarded as characteristic of immaturity include apathetic, erratic, purposeless, illogical, poorly organized, indecisive, low aspirations, impulsive, dependent, self-centered, unfulfilled potential, unpredictable, etc.

[45]See Franklin C. Schontz, *Research Methods in Personality* (New York: Appleton-Century-Crofts, 1965), p. 70.

the meaning of affirmation (agapaic love) within the context of the essential message of the Christian Gospel.

In Part II, Chapter III will offer an explanatory outline of the human phenomenon of spinal cord injury in its various aspects which will provide the background for a consideration of the *Sitz im Leben* of the person with spinal cord injury in Chapter IV and the presentation of research findings and of person-world reviews in Chapter V.

In Chapter V (Part III) spinal cord injury will be viewed from the onto-theological and pastoral counseling perspectives with illustrations of the experience and incorporating a consideration of cultural, societal and religious attitudes.

Chapter VI will contain summaries and conclusions based on the research findings and will review the implications of the study for pastoral care and counseling within the concept of comprehensive rehabilitation of persons with spinal cord injury, together with recommendations for further investigation in this area of irreversible physical disability.

CHAPTER II

MAN AND HIS BEING

A. THE NATURE OF HUMAN EXISTENCE

To understand the person with spinal cord injury it is important to start first from ontology, to learn what he shares in common with all other human beings, e.g. the structure and the processes of life, and then to proceed to the psychological and other implications of his behavior towards self-affirmation in the light of his own particular anxieties and life situation.

Paul Tillich presents a systematic analysis of the fundamental patterns of human existence which he illumines with the relevance of the Christian Gospel. In this section of the dissertation an attempt will be made to relate the phenomenon of spinal cord injury to this ontological and theological understanding and analysis of man. The justification and method for this approach is contained in the term "correlation."

1. Tillich's Method of Correlation

Tillich employs "correlation" specifically in three theological meanings: (a) as a correspondence between religious symbols and that which is symbolized; (b) as the interdependence of world and God, e.g. being-God, finite-infinite; (c) as the interdependence of things or events within a whole, e.g. human-divine relationship within religious

experience.[1] The method maintains a mutual and interdependent connection between two areas, or two separate and distinct entities; e.g. as correlation between self and world, existential situation and *kerygma*, culture and theology. Although a distinction is drawn between the two sides of the correlation, neither side determines the content of the other.

In the relationship between psychology and theology, the application of the method of correlation proceeds by way of question and answer. The method explains the contents of the Christian faith through existential questions and theological answers, which must not prejudice each other. The theological answer is not made in terms of the human situation *per se*, but from beyond it.[2] Tillich correctly differentiates his theology from the apologetic and kerygmatic theologies as an "answering" theology employing the method of correlation, or it may be called the principle of polarization. From the phenomenological approach, John B. Cobb, Jr., points to what is meant by "polarities":

> When I examine my own given existence, I discover that in my total being I am deeply divided. On the one hand, I am aware of an ideal or normative possibility for my being. On the other hand, I am aware of an actualized being that falls far short of the normative possibility. I perceive the former as my true being, my essence. The latter is my empirical actuality, my existence.[3]

---

[1]See Paul Tillich, *Systematic Theology* (Chicago: University of Chicago Press, 1967), I, 60-61.

[2]See Tillich, *Theology of Culture* (New York: Oxford University Press, 1959), pp. 123-25.

[3]John B. Cobb, Jr., *Living Options in Protestant Theology* (Philadelphia: Westminster Press, 1962), p. 266.

As has been seen, a polarity means a pair of terms which face in opposite directions, but which at the same time demand each other. There is a balance between these two separated but related elements. Tillich speaks of "a unity of dependence and independence of two factors." And at another point, he describes a polarity as a relationship in which "each pole is meaningful only insofar as it refers by implication to the opposite pole."[4] Tillich struggles with the concept of the "opposite." Polar conditions often refer not to the "opposite" but rather to the conditions and limitations in a polar relationship. The best example of this is the relationship of freedom and destiny.

The method of correlation replaces three inadequate methods of relating the contents of the Christian faith to man's existence. The first method can be called "supranaturalistic" in that, as in Karl Barth, it takes the Christian message to be a sum of revealed truths which have come to man from "a strange spiritual world." Within this framework of thought, no true mediation in the human situation is possible. Here man must become something else than human in order to receive divinity. If the Bible was a book of supranatural "oracles," man would have received answers to questions he had never asked. This would rob man of the core of very existence.[5]

The second method rejected by Tillich may be called "naturalistic" or humanistic. This method, as in Wieman, derives its message

---

[4]Tillich, *Systematic Theology*, I, 165; II, 13.

[5]*Ibid.*, I, 65.

and answers out of "human existence, unaware that human existence itself 'is' the question." It identifies man's existential with his essential state, overlooking the obvious break between them, which is reflected in the universal human condition of self-estrangement. Questions and answers were put on the same level of human creativity. Everything was said by man, nothing to man. But revelation is "spoken" to man, not just by mankind in search of answers to this existence.[6]

The third method to be rejected is called "dualistic," in that, as in Luther, it builds a supranatural structure on a natural substructure. Here there is an infinite gap between man's spirit and God's spirit, but it does not deal sufficiently with the problem. Instead, it tries to express a "positive relation" between them by positing a body of theological truth which man reached on his own efforts, i.e. in terms of a contradictory expression, through "natural revelation." The arguments are true insofar as they analyze human finitude and the question involved in it. They are false insofar as they derive an answer from the "form" of the question. The method of correlation solves this historical and theological riddle by resolving natural theology into the analysis of existence and by resolving supranatural theology into the answers "spoken" to the questions implied in existence.[7]

Thus, the method of correlation fits suitably the relationship of mutual interpenetration between psychology and theology in that a

---

[6] *Ibid.*

[7] *Ibid.*, I, 66.

continuing dialogue is maintained in which psychology is not theologized, nor theology psychologized. Each side of the correlation preserves its own identity, yet focuses on the common issue of man's existential predicament and his essential being. This involves a recognition of the radical distinction between man's essential and existential characteristics which will now be examined.

2. Essential Man and the Ontological Polarities

To refer to man as he essentially is is to refer to his potentiality, what he ought to be, as opposed to what he actually is, in his existential estrangement.

Tillich asserts that man must be viewed in terms of the basic ontological structure of self and world. This is something more than having a mere environment. The world is the "structural whole which includes and transcends all environments--but also the environments in which man partially lives."[8] By having a world man is not limited wholly by his environment, unless he has lost his humanity through insanity or intoxication. He is able to transcend his world by "grasping and shaping it according to universal norms and ideas. Even in the most limited environment man possesses the universe; he has a world."[9]

For man, the world is his view of himself and his environment. When he sees himself he sees himself as a part of his world. This

---

[8] *Ibid.*, I, 170.

[9] *Ibid.*

enables man to have a relationship with himself. Self and world are indispensable correlates in that man's world is inconceivable without a self engaged in the perceiving.

The following polarities must be seen as expressions of this polarity of self and world.

(a) Individualization and participation: To describe man as a self is to imply self-consciousness; a self which is aware of itself. Man is a 'centered' self, that construct of being which is the center of all its experiences and relationships. There exists something that "has" the experience and relationship and something which is "had" in or grasped by the experience and relationship. Tillich uses the analogy of the invisible geometrical point which remains a unit, maintaining its identity and integrity.[10] The self is also a centered being resisting partition. Although it can be destroyed in its encounter with another self, it cannot be assimilated.

Man as self-conscious is enabled to stand outside or beyond himself and to contemplate various aspects of his being.

In this self-transcendence he is distinguished from organic beings. Man is not only aware of his being, his existence, but he also knows that he knows. Self-transcendence gives man the capacity for abstract reasoning, using language, and developing a sense of freedom and relatedness to a ground of being beyond himself, including other human beings and God.

---

[10] *Ibid.*, I, 175.

Self-awareness incorporates an awareness of what is apart from the self: the environment. Selfhood means remaining separate while at the same time interrelated with one's particular environment. This is the essence of the self-relatedness of all being. A person's environment includes the physical and social contexts of his being. He possesses a body and is subject to physical and biological norms; by both he enters into a family, a community of persons in a socio-economic situation. In addition, these physical and social aspects represent a moral and spiritual environment which a person experiences as love. Man's relationship with his environment is characterized by mutuality. Because of his knowledge that he is and exists, he claims from others in his immediate environment an acknowledgment of his "isness." Recognition of his being by other human beings is equivalent to the appreciation of his worth and value as a person and an important step in the direction of the essentialization of his various potentials as a human being in his own right. As has been observed the primary thrust or urge in man is his longing for the reunion of the separated and the fragmented; man with aspects of himself, man with other men, and man with God. Tillich describes this urge as love, understood initially as self-affirmation.

In this context it is noteworthy that the biblical view of man differs from that of an example of some universal idea. Man is seen rather as a person--a unique individual being. Hence the biblical view is a reflection of an ontological reality which no one successfully ignores. Certainly, the individual does not exist apart from

his relationships with other people; but he does exist in polarity with his participation in the relationship. In other words, he is not synonymous with his relationship.

Man's relationships with others form the only area in which he participates fully, for here he can have communion which is essential to his well-being.

> No individual exists without participation, and no personal being exists without communal being. The person as the fully developed individual self is impossible without other fully developed selves. . . . Therefore, there is no person without an encounter with other persons. Persons can grow only in the communion of personal encounter. Individualization and participation are interdependent on all levels of being.[11]

(b) Dynamics and form: In this polarity dynamics is that potentiality in man which has not yet taken form. It is that innate thrust of being which drives towards its own fulfillment even at the cost of change in the very structure of the person's life.

Man experiences dynamics as vitality--the creative drive towards new forms. He experiences form as intentionality, by which Tillich means "living in tension with (and toward) something objectively valid." Intentionality keeps man's vitality from being undirected and chaotic; it shapes and directs it towards a meaningful goal. Neither dynamics nor form ever exist apart from the other. Consequently, life moves towards the actualization of potential even when this means drastic change and the alteration of old structures. But life also conserves part of the old structures so that continuity occurs simul-

---

[11] *Ibid.*, I, 176.

taneously with change. Continuity and creative change are both included in the structure of life; neither destroys the other.

(c) Freedom and destiny: This polarity appears rather surprising, accustomed as many of us are to viewing freedom contrasted with necessity rather than with destiny. Tillich maintains that possibility, not freedom, is the contrast of necessity. Whoever speaks of freedom must place it in polarity with destiny.

A person experiences freedom first as deliberation over the motives, trends and other factors involved in making a choice; then, in making a decision (Latin: *decidere*)--the cutting off of those possibilities not chosen and the commitment of one's centered self to the possibilities that are chosen. Finally, man experiences freedom as responsibility for the choice or decision made. The decision-maker is required to answer for his decision if he is summoned to do so.

Destiny concerns the source from which our decisions are made and is not to be confused with fate which is simply a contradiction of freedom. Destiny has more bearing on the limitations to freedom rather than being its contradiction. It includes the bodily structure, the drives, the accumulated results of past decisions, the political, social and economic conditions in which a person finds himself--in other words, it is the 'givenness' of one's life. Within the possibilities and limitations of this givenness man expresses and experiences his freedom. He deliberates, decides and judges which possibility will be fulfilled.

Just as in the case of the other polarities, freedom and

destiny stand in interdependent relationship with each other. If a person loses one he automatically loses the other.

3. The Problem of Finitude

Man is finite, finding himself caught between being and non-being. He shares in both and in their struggle with each other. Finitude is, in fact, being limited by non-being. "Nonbeing appears as the 'not yet' of being and as the 'no more' of being. It confronts that which is with a definite end (finis)."[12]

Man, as he participates in being, discovers that he is also participating in non-being. Although man is not necessarily aware of this at any given moment, there are times when non-being breaks through to his awareness, especially in the events of cataclysmic change such as spinal cord injury. At these points man becomes anxious. His anxiety signals his having become aware of his possible non-being, irrespective of his ability or inability to articulate this.

(a) Finitude vis-à-vis the ontological categories: Man's finitude is effective in each of the four categories (time, space, causality and substance) with which man understands and shapes reality.

He experiences time in the impermanence and transitoriness of all things including himself. Admittedly, there is a positive aspect of time in that it is creative, fulfilling, and capable of solving problems. Man's recognition of this positive element has given rise

---

[12] *Ibid.*, I, 189.

to such a popular saying as "time heals all wounds."

But time also brings about the destruction of everything, including man, a fact of which he is painfully aware. The present moment is all that man really possesses for certain. In accepting this fact, he becomes aware of his finitude.

Man is also confronted with the fact that there is no space he can call his own. No specific space belongs to him as his possession. No matter what he does to 'make a place' for himself through effort, status, wealth, etc., he is faced in the end with the realization that he does not 'own' his place. He can easily lose it; this means ultimate insecurity.

Concerning causality, man becomes aware that he is contingent --that he does not cause himself, but is caused. That which causes him to be can also cause him not to be.

Concerning the category of substance, man becomes aware that change might affect not only whatever is accidental to him, but also his very identity. He observes that some things subjected to change are unable to resist the attrition of non-being and that in being destroyed they are replaced by the new. This applies to man's very substance--his identity--as well as to the accidental aspects of his being.

(b) Finitude vis-à-vis the ontological polarities: Man experiences non-being in connection with the ontological polarities or elements in a way which differs from his experience of non-being in connection with the categories. Concerning the categories, his

experience of the anxiety of non-being is direct. In the case of the ontological polarities, he experiences non-being as the possibility of not being what he is essentially. He experiences the threat of tension and also disruption of unity among the polarities.

The unity between individualization and participation can be disrupted by the impact of finitude so that the person is in real danger of losing first the one and then the other. On the one side, he stands in danger of becoming isolated from his world in static self-identity and on the other side, of becoming totally absorbed by his world and losing his identity. Among expressions of the disruption of this polarity are the many sociological and psychological problems ranging from the psychotic who has retreated into his tortured world of fantasy to the collectivism of communism.

Where dynamics and form are disrupted, a person stands in danger either of being involved in change for the sake of change, which can be chaotic, or of being imprisoned in inflexible forms which stultify his vitality.

Where freedom and destiny are disrupted, the danger facing man is the surrender of his freedom for the sake of preserving his destiny. Simultaneously, he stands in danger of attempting to save his freedom by denying his destiny. Man, therefore, lives in constant danger of losing his essential selfhood beneath the tremendous weight of finitude.

4. Being and Non-Being

Whenever a person, at any given moment, is confronted by the

necessity of choosing between affirming or negating himself, he acts as someone who is already related ambiguously to his essential nature --related, but also estranged. This condition of his life is permanent and is overcome only fragmentarily. The impact of finitude has brought him to this condition and this impact still weighs on him when, at this precise moment, he must decide for or against self-affirmation. To understand what is involved in that decision necessitates an understanding of how the person experiences the impact of finitude.

Tillich describes finitude as being, limited by non-being. Man's awareness of non-being causes him to be anxious. Anxiety here does not mean a theoretical or intellectual knowledge of non-being. It could be agreed that every person dies and no concern at all may be expressed at that fact. But if the person is involved in an accident or loses a close friend or relative and subsequently realizes that the fact of death is not something remote, but that it is his destiny that he will die sometime, perhaps even at this very moment, then he becomes existentially aware of his possible non-being. In this awareness he views death as his own death and recognizes it not only through his intellect but also through his imagination, his emotions and his bodily reactions--his entire being.

Man is anxious whenever he becomes existentially aware of non-being. To be understood clearly, this anxiety needs to be distinguished from fear--which is felt when a person faces an object which he sees as threatening to him. This object can be

> faced, analyzed, attacked, endured. One can act upon it, and in acting upon it participate in it--even if in the form of a struggle. In this way one can take it into one's self-affirmation.[13]

But the problem remains of what a person can do when nothing exists to struggle with, analyze, or attack? A threat of danger is there but one cannot do anything about it.

> Helplessness in the state of anxiety can be observed in animals and humans alike. It expresses itself in loss of direction, inadequate reactions, lack of 'intentionality' (the being related to meaningful contents of knowledge or will). The reason for this sometimes striking behavior is the lack of an object on which the subject (in the state of anxiety) can concentrate. The only object is the threat itself, but not the source of the threat, because the source of the threat is 'nothingness.'[14]

One ought not to assume that it is only the fact that the source of the threat is unknown which causes anxiety rather than fear in the person experiencing it. It is the nothingness, the non-being behind the threat, which creates anxiety. The source, therefore, is unknown, because it cannot be known. It is non-being.

Anxiety and fear are nevertheless interrelated, despite the difference between them. "They are immanent within each-other. The sting of fear is anxiety, and anxiety strives towards fear."[15]

Fear is the awareness of the danger of some specific threat, e.g., a loss, a failure, a rejection. Anxiety, on the other hand, is

---

[13]Paul Tillich, *The Courage To Be* (New Haven: Yale University Press, 1952), p. 44.

[14]*Ibid.*, p. 45.

[15]*Ibid.*, p. 46.

the awareness of the implications of the threat. Tillich uses the illustration of the fear of dying:

> Insofar as it is *fear*, its object is the anticipated event of being killed by sickness or accident and thereby suffering agony and the loss of everything. Insofar as it is *anxiety*, its object is the absolutely unknown 'after death' the non-being which remains non-being even if it is filled with images of our present experience.[16]

Such an illustration is valid for the anxiety in every fear. The anxiety may appear to be anxiety concerning the ability to cope with a certain problem. But behind the immediate problem is the human situation itself which is exposed by the particular problem. It is the person's sense of helplessness--his anxiety over the inability to secure his being against the threat of non-being. The particular problem represents a symbol of this larger threat and reveals the power of this threat to the anxious person.

Man tries to turn anxiety into fear because of its extremely devastating effect on him. He endeavors to find a definite object to fear and a specific danger threatened by this object, e.g. a professed communist will fear his neighbors or certain politicians, businessmen or professionals, etc. Although his 'evidence' concerning their being dangerous is flimsy, it is not the evidence itself, but rather his need to avoid anxiety by turning his anxiety into fear, which makes him believe these people are dangerous. He senses that the anxiety which his projections are designed to hide is far more real and dangerous than the fear which those projections symbolize.

---

[16] *Ibid.*

However, as a protection against anxiety, these projections, as well as many other defenses, are very limited in their effectiveness. The fact remains that anxiety is a normal part of human life. It constitutes the awareness of man's finitude--of non-being.

For the person with permanent disability anxiety becomes two-pronged: in one direction it is seen as active energy pushing and stimulating his being towards reunion with all other being; in the other as fearful awareness that such reunion may not be possible. The latter kind of anxiety drives a person to try to grasp his acceptance. When his fear of rejection clashes with the acceptance of his being by the Ground of all being, he feels cut off by the Ground of his own being. This estrangement may represent his being cut off from present time, including loss of the past and future and being cut off from freedom to be. It is experienced as despair, ultimate rejection, ultimate destiny and restriction upon his finite freedom to choose to have faith in his acceptance. There is a projection of this onto the structure of reality, so that other persons and the environment are perceived as rejecting. In its extreme form, this is paranoia, an exaggerated suspicion about the entire structure of reality, including other people. When there is a threat of separation from self-affirming sources, this can assume such large proportions that in his anxiety the person with a disability may gravitate towards those who are like-minded and in similar physical condition in an effort to receive some degree of acceptance which he may perceive, rightly or wrongly, is not coming from friends, family or a particular cultural environment.

In this extreme sense, essence and existence are no longer in creative tension. Both life and the world are seen as rejecting, and the ontological polarities are out of balance. Such a person falls prey to despair and becomes immobilized by the existential anxiety of non-being. This involves a failure to face his finitude and a phoniness in trying to deny his real need to feel loved by others. In this respect William Glasser discusses the problem of taking responsibility for one's own life and its direction.[17]

The person with spinal cord injury who fears accepting his finitude takes the attitude that he must be perfect before he can be loved, i.e. bodily-whole, completely secure and always certain. He assumes, therefore, that love is conditional and conditioned on his success or failure to measure up to unrealistic and extreme expectations or standards set by himself or by others, either in reality or imagination. He has a compulsive and unremitting urge to work hard to prove himself acceptable. He believes he must become like God in order to be liked by God and others. This is similar to the grandiosity described by Camilla Anderson in "The Pot and the Kettle."[18] It is pride (*hubris*), arrogance amounting to "sin" and is really a one-sided demand by a person for affirmation of his "self" while denying affirmation of the "selves" in others. Basically, it is a lack of

---

[17]See William Glasser, *Reality Therapy* (New York: Harper & Row, 1965).

[18]Camilla M. Anderson, "The Pot and the Kettle," in O. Hobart Mowrer (ed.) *Morality and Mental Health* (Chicago: Rand McNally, 1967).

faith in God and is expressed in all sorts of pretense to mask a person's finiteness about which he is perpetually anxious. Through this pride he becomes intolerant with his failures, especially his failure to accept his humanity and consequent fallibility. He experiences this as guilt and creates as compensation a false and unrealistic self-image, which he must preserve in fact at all costs, otherwise he imagines he will disintegrate and perish. When he finds himself unable to maintain this self-image, he feels helpless and begins to express rage or experience depression, which breeds resentment and guilt. This pride, as Camilla Anderson points out, is not easily detectable, for it masquerades in all sorts of disguises. It often parades as self-devaluation, timidity, fear of trying, false modesty, self-effacement, humility, sensitivity, moaning over inadequacies or wanting to be no better than, but just as good as, the next person. Or it may appear as smug quietness or arrogance, in self-pity or self-contempt, in one who must always be right or the perfectionist, the obsessive-compulsive, or in the role of the perpetual donor or do-gooder. Usually the grandiose person has no idea of his condition.

The denial of finitude is an expression of doubt or lack of faith in the possibility of unconditional *agape* love. On the assumption that he will be rejected, the person seeks, by whatever means he can muster, to force, cajole, or manipulate self-affirmation from others. Theologically, this denial is tantamount to an expression of sin. It is sin in that it tries to demand from others the confirmation of a person's own self-worth, which can only be given by others as a free

gift of love. Man sins whenever he attempts to hide the finiteness of his being. He tries to earn love through a religion of works salvation. This type of sin is the denial of man's real nature as limited and limitless, free and bound. It expresses itself in a person's fear of living within the tension between the polarities of his being. Such behavior perpetuates itself. When a person continually doubts and is unaccepting of the confirmation of his own worth which is offered to him, he refuses to take the very gift which could finally satisfy his need for love. Acceptance of another's love would mean an end to demanding it and to self-destructive behavior.

Basically, the permanently disabled person is anxious in onto-theological terms.[19] The characteristic negative expressions of anxiety include, besides denial of finitude, withdrawal, possible anti-social hostility, dependency or compulsive achievement. All are efforts to minimize the threat of loss of one's being through rejection. Such behavior illustrates a disunity of the ontological polarities. It results in an attempt to avoid the pain of existential doubts and uncertainties, the possibility of unfulfilled potentials and broken human relationships. It can amount to the destruction of one's own centeredness which includes not only the disintegration of the self but also of one's world. In therapy, firm confrontation of such behavior may be necessary.[20]

---

[19]See Section B, post, p. 66f.

[20]For the discussion of the types of pathological anxiety viz. unrealistic security, unrealistic perfection and unrealistic certitude see Tillich, *The Courage To Be*, Chapter III, p. 69f.

Only the type of affirmation which offers the permanently disabled person the freedom to risk himself even to the point of failure and yet be loved, is sufficient to provide the hope and fulfillment that he needs. The *agape* type of love implies an acceptance by the donor of the disabled person as one who is lovable and acceptable, even though finite in his inactive, immobile state, and still striving towards potential as yet unrealized. This is the basis of Tillich's "courage to be," in other words "faith," in religious terms, which allows the acceptance of one's acceptance by others and the Ground of all Being.

5. The Courage To Be

The courage which makes it possible for man to affirm himself in spite of the existential anxieties has to be one in which the power of being is effective despite the power of non-being. Effectiveness in the power of being means the overcoming of existential estrangement, even though fragmentarily.

Man experiences the power of being as spiritual presence, "a meaning-bearing power which grasps the human spirit in an ecstatic experience."[21] He experiences it as the shaking and transforming power of the New Being in which he shares and which unites him with his essential being. He experiences it as a manifestation of the ground of being in its healing power.

A distinction must be drawn between this ecstatic experience

---

[21]Tillich, *Systematic Theology*, III, 115.

and the ecstacy of intoxication. Intoxication can result from drinking alcohol, espousing a cause, 'falling in love' or anything else which tends to release one momentarily from the weight of existence. Counseling observes the search for existence as an attempted means of making the neurosis work. Intoxication could be said to be due to the illusion that a person has escaped the destructiveness of the neurosis without the pain of surrendering the neurosis itself.

Theodore Reik has demonstrated that falling in love resembles a religious conversion in which the lover feels himself to be forgiven for his shortcomings. But the feeling which is temporary disappears when he realizes that the shortcomings still exist within him.[22] Tillich indicates that intoxication is not only temporary but also destructive because it intensifies the very destructiveness from which it gave temporary relief. This raises the issue of a criterion to distinguish between the ecstacy of intoxication and the ecstacy of the spiritual presence. Tillich states that the criterion is the presence of creativity in the ecstacy of the Spiritual Presence and its absence in the ecstacy of intoxication.

When a person is grasped by the Spiritual Presence or, to describe it otherwise, is grasped by the New Being as ultimate concern, the preliminary concerns on which his unbelief, *hubris* and concupiscence have focused, are shown to be preliminary. Their preliminary nature is exposed in contrast to the ground of being whose ultimacy

---

[22]Theodore Reik, *Psychology of Sex Relations* (New York: Grove Press, 1945).

takes hold of the person.

When this occurs, man is offered healing for the existential estrangement in his life. Growth, integration, and self-transcendence become possible less ambiguously than is usually the case. Pastors and pastoral counselors often observe examples of this when ministering to persons who have recently faced death--either that of someone close to them or their own death. People who are mourning the loss of loved ones are occasionally puzzled and even embarrassed by the increased joy of being alive which is sometimes part of experiencing grief. A man with a recent heart attack may very well feel a new man as a result. Included in this ecstatic experience is a disturbance of one's values and commitments which accompanies self-integration, self-creativity and self-transcendence. A reorientation of one's life is involved. Previously important matters are seen as trivial and not worth the anguish and hostility they once caused, while matters that had been formerly overlooked become manifestations of life's holiness and invitations to personal fulfillment. This might express itself concretely as reduced interest in petty complaints about others and increased appreciation of their essential worth together with a greater desire to participate in the centers of their beings.

The Power of Being can use any person, thing or experience to reveal itself to man. When it does manifest itself through grasping a person, its grasping is that person's acceptance by the ground of being. As will be seen, the question is whether this acceptance can supply the courage to be "in spite of" the anxieties

which the awareness of non-being stimulates.

B. AN ONTO-THEOLOGICAL UNDERSTANDING OF MAN

At this point, having examined Tillich's analysis of human existence, we pause to consider his approach to the nature and structure of being in slightly more detail before proceeding to discuss the life processes of man which are important in considering the *Sitz im Leben* of a spinal cord injury person.

The term which Tillich uses is "onto-theological" which is intended to stress man's fundamental identity as a being in relation to the Ground of all being. The ontological aspect arises from the presumption of a subject-object structure of existence and the issue of non-being, viz. negation of being. The theological aspect arises from the assumption of an ultimate ground and reality beyond itself. Martin Heidegger, from a metaphysical perspective, uses the same term "onto-theologic" and views it as connecting being *per se* to the whole of existence in all forms, which is the generative ground of being.[23] This model of man differs from the traditional forensic perspective in theology in that it speaks of existential anxiety and guilt instead of theological sin and guilt, of self-acceptance rather than justification by faith, of the courage to be oneself instead of divine forgiveness, and of the New Being rather than the transformed sinner or imputed righteousness. "God" is referred to symbolically, not as "a"

---

[23]Martin Heidegger, *Identity and Difference* (New York: Harper & Row, 1969), pp. 15, 54.

being, but as the basis and process of life itself, uniting unconditionally the ontological polarities, sharing in every aspect of existence and participating in its destiny. "God" is the Ultimate Ground of Being, known as Ultimate Concern, as the Power of Being and the Power of Love.[24]

In contrast to the stance of traditional, forensic theology, the onto-theological view of man avoids an absolute dualism between man and God, as separate entities, and within man, between soul and body. Nor does it insist that finite being cannot be acceptable as it exists but must first be changed and made righteous. It maintains, however, that there is only one ground of existence and only one reality, in which alone the ultimate quality or dimension of reality is found. "Holiness" and bodily and mental wholeness are united together in a conjunction of body and soul. As Joseph Goldbrunner remarks, holiness "is bound up with an authentic human life and with the uniqueness, with the limited talents and potentialities of the individual which are his truth" rather than being an imitation of certain "spiritual" attributes (at the expense of and punishment of the body).[25] This means that man is not devalued because of his finite being nor is his individuality absorbed into the identity of Ultimate Being. Instead, man though finite is transformed by the Power of Being itself. The key attitude underlying the possibility of this

---

[24]Tillich, *Systematic Theology*, I, 163, 244 and 245.

[25]Joseph Goldbrunner, *Holiness is Wholeness* (New York: Pantheon, 1955), p. 27.

healing and wholeness (as reunion) is faith. Tillich states that faith "means being grasped by a power that is greater than we are, a power that shakes us and turns us, and transforms us and heals us."[26] For Tillich, acceptance of faith means having the courage to "accept one's self as something which is eternally important, eternally loved, and eternally accepted."[27] When man accepts God's acceptance of him in this way, he then has the courage and power to overcome his existential estrangement. What follows is wholeness, the reconciliation of man's being with the Ground of all being described as the "New Being." This is not just the old being merely changed by a radical act of God but rather a new reality in which the self-estrangement of man's existence is overcome, and reconciliation, meaning and hope and creativity are actualized.[28]

Martin Buber's thesis of two types of faith also points to the difference between the traditional forensic and onto-theological perspectives. Buber distinguishes between faith as (1) trust in a person without reason as a basis and (2) the acknowledgment that a thing is true without reason as a basis.[29]

Faith as trust describes man's relationship to the unconditioned

---

[26]Paul Tillich, *The New Being* (New York: Charles Scribner's Sons, 1955), p. 38.

[27]*Ibid.*, p. 22.

[28]Tillich, *Systematic Theology*, I, 49.

[29]Martin Buber, *Two Types of Faith* (London: Routledge and Kegan Paul, 1951), p. 7.

in which he finds himself as a member of a covenant community instead of being "converted" to faith. In this, the crucial factor is the "contact of my entire being with the one in whom I trust."[30] As a trust relationship, faith stresses a direct contact between two entities in which unconditional love of the person as person is central and his worth is affirmed. In his acceptance into the community there are no prerequisites of change. This is the very basis of the onto-theological understanding of man. Buber believes that Jesus of Nazareth embodies and illustrates this kind of faith.

To enter faith as acknowledged truth, man must undergo "conversion," which is tantamount to his being a person who is not acceptable as he is but who must be changed before he is worthy of being loved and accepted. Here an isolated individual is converted and the community arises as "the joining together of converted individuals."[31] This describes the way of conditional love where the act of acknowledging the truth is important before being converted to it. The obligation for man's being to be changed before he is acceptable or worthy is a legalism which insists that justification can take place only after conversion based on an "act" of acknowledged truth. Buber views this attitude as that of classical Christianity represented by the forensic theological and ascetic-legalistic approaches. Here faith requires specified actions before a man's being is affirmed as worthful and acceptable.

---

[30] *Ibid.*, p. 8.

[31] *Ibid.*, p. 9.

It is interesting to note that John B. Cobb, Jr., by contrast, contends that the basic relationship between man and the Unconditioned (to use Buber's term) is not one of trust through faith, but rather one of love through faith leading toward trust. The seat of Christian existence is love.[32] The type of faith based on a trust relationship and exemplified in Jesus takes seriously the radical distinctions between the essential and existential characteristics of man's being.

Regarded *essentially*, man is viewed in respect of his potentials for growth, change, freedom and relationships with all the various aspects of his world, socially, religiously, etc. In other words, what he ought to be rather than what he actually is. Finitude, including limitation in time, space, causality and substance, constitutes the setting for these essential aspects of man's being which is limited by non-being. Thus he can affirm himself by using his potentials for growth or freedom or relationships with others, or he can equally be isolated by his individuality, overwhelmed by his destiny and atrophied by his attitudinal or moral inflexibility.

Regarded *existentially*, man is viewed as an ambiguous amalgam of essential and existential elements. He is not what he is essentially. Tillich uses the terms unbelief, *hubris* and concupiscence to describe the modes of man's separating himself from the Source or Ground of his being. Man deliberately chooses in each of these three ways to separate himself from his world, which is the context of his being. This action also implies the loss of his self. Man is

---

[32]Cobb.

characterized as he essentially is through such alienation or estrangement.

In the Judaeo-Christian tradition, the idea of the "Fall" has been advanced to explain his abuse of his finite freedom and his rejection of the Ground of his being. Described existentially, man is limited by sin, meaninglessness, emptiness, guilt and death. If he is to make progress towards any reunion with the Source of his being, he must continually confront these expressions and threats of non-being with some sense of self-confirmation. As we have seen, finitude is being limited by non-being--life limited by death. In man, non-being is ambiguously intertwined with being. His awareness of such limitations creates existential anxiety which is best exemplified in the forms of fate and death, guilt and condemnation, emptiness and meaninglessness. In facing these anxieties, man has really two alternatives:

1) He can affirm himself, his being, despite the threat of non-being by accepting the divine acceptance of his being in the face of fate, guilt, meaninglessness. The result of this choice will be self-integration, self-creativity and self-transcendence, which means having the courage to live in spite of existential anxiety, because one's being has been grasped by the Power of all being.

2) He can become the victim of an existential vacuum, in which he lacks the courage to affirm himself because of or in the face of the threat of non-being and is overwhelmed by a feeling of loneliness, despair and meaninglessness. The inevitable result is a life-style

of self-disintegration, self-destructiveness and self-profanization.

The onto-theological understanding of man indicates a sense of transcendence in the dialectical interaction of the ontological polarities. The subjective-objectivity which is implied is crucial in man's realization of his limited freedom. Tillich's concept of finite freedom forms a bridge between the existentialist view that man is mainly controlled by forces, laws, etc., and the kind of extreme radical freedom which Jean-Paul Satre advanced in implying that man is his choices and is his freedom. This involves a tension between freedom and destiny rather than an either/or dichotomy.

The hyphen between onto- and theological indicates the acceptance of the "for-me-ness" of the Ground of all being based on the recognition of the courage to be despite the anxiety about non-being. It also points to the crucial process by which a person in his finitude as a human being is accepted and yet transcended to enable him to enter a fuller realization of his being and his identity as a new being. He becomes truly the "human" being he was meant to be and may be likened to Jesus Christ, who for Tillich is *the* example and model of what it means to realize one's true essence and who mediates the New Being. This process is nothing less than the acceptance of a gift from the Ground and the Source of all being by whose power man is grasped. This power of affirmative love is the acceptance of one's acceptance by the very Ground of all being; in religious terminology it is the experience of restoration: salvation. The result is an end to all estrangement between man and the Source of his being and his sense of increased

freedom and power to risk the loss of his being in order to discover his true being and his real identity as a being in the process of ever fuller becoming. As will be seen in the following section this process of creative growth is akin to "maturity."

C. THE LIFE PROCESSES: MATURITY AND IMMATURITY

In this section of the study Tillich's ontological polarities in terms of the life processes of self-integration, self-creativity and self-transcendence will be reviewed and described with specific application to Douglas Heath's psychological categories of maturity.

For some time, the meaning of maturity has engaged behavioral and social scientists in controversial argument. For some, like Piaget, it may denote the patterns or time sequence of human growth and development assessed in terms of knowledge or emotions. For others, it may involve the successful completion of designated tasks in specific phases emerging under certain physical and social conditions. In this respect, Erik Erikson's epigenetic principle envisages the development of various potentialities for maturity in terms of a time or age, with considerations for the completion of the previous stage which in turn opens up a new stage with its own life tasks. Each stage emerges long before the previous stages are completed, with the whole developmental growth like a continuing expanding process. Here the emphasis is a biological one with the focus on the psychosexual environment. Besides stressing the "identity crises" of childhood and adolescence, Erikson also refers to the importance of the completion of maturity in

the stage described as "ego integrity."[33] Maturity may also refer to the kind of life-span view advanced by Pressey and Kuhlen in which all that is required for development is already present at the time of birth and merely has to be lived out. Here the biological environment is regarded as secondary to the cultural and socio-economic environments which are the specific concern of those in adulthood.[34]

1. Tillich's View

For Tillich, man's life is a multi-dimensional, ambiguous process in which polar opposites desire to be united or reconciled unambiguously. He describes it thus: "Every life process unites a trend towards separation with a trend towards union. The unbroken unity of these two trends is the ontological nature of man."[35] Man's polarities point to the polar elements in the identity of God in whom alone they are perfectly balanced.[36] It is only in the relationship of each polar element to its opposite that each pole receives its meaning. Because each pole needs the other to confirm its own unique identity, there is no contradiction between them. The ontological polar elements reflect the basic polarity and correlation of self and world. In the

---

[33]See Erik H. Erikson, *Childhood and Society* (New York: Norton, 1950) and also Erik H. Erikson, *Identity and the Life Cycle* (New York: International Universities Press, 1959).

[34]See Sidney L. Pressey and Raymond G. Kuhlen, *Psychological Development Through the Life Span* (New York: Harper & Row, 1957).

[35]Tillich, *Systematic Theology*, I, 279.

[36]*Ibid.*, I, 243f.

fundamental ontological structure, the self or subject aspect is represented by the elements of individualization, dynamics and freedom, whereas the world or object aspect is observed in the elements of participation, form and destiny. Both aspects find their roots in the life of God.[37]

Although Tillich's approach to maturity is basically theological and philosophical, he employs psychological insights in describing the interrelatedness of all aspects of man's life and world. Tillich understands maturity in two ways:

1) As the full development of man's potentials in an ongoing, dynamic, actualizing process. Here maturity is equated with man's becoming fully human. This is not equivalent to man's having become perfect like God, but rather to his having approximated more to the nature of Jesus Christ as the New Being, the example and model of what man is meant to be and to become. It is through his increasing awareness of the influx of the Power of Love and Being into his own life and his resolve to actualize this power that his full maturity is characterized and achieved. This results in his own self-affirmation through accepting the moral imperative to love his neighbor as himself, and in his own self-confirmation through loving that neighbor as he is loved by God, the Ground of Being Itself. Here he lives in the spiritual dimension of life wherein *agape* love is the expression of one's life. Reuel Howe suggests that maturity is characterized by the "ability to love others so satisfyingly that he becomes less dependent

---

[37] *Ibid.*, I, 243.

on being loved. Love of the enemy is the most mature experience of love."[38]

The person who is in the process of becoming mature knows that he can never say he has "arrived," nor that his life will be conflict-free. He is always learning and taking risks. For him, life's ambiguity consists in the mixing of freedom limited by destiny; of love of others with self-interest, of double values, of life with the ever-present possibility of death. *Agape,* the power of love, creates within him increasingly new opportunities for growth, emotionally, physically, morally and spiritually. In accepting and believing in the Power of Love, he can say "No" to repressive authority, protection, traditions of conformist security and, more important, is able to say "Yes" to the actualizing movement of life, towards independence, responsible freedom and creative change.[39] The presence of the Power of Being and Love in every human being, irrespective of his knowledge or ignorance of its existence, means that the capacity for maturing is embryonic in each person, despite the most extreme situations of existential change and alienation. However, the measure of maturity present in any given human being at any time is a relative matter and will depend on his own unique destiny. This means that each individual is not equal in abilities and physical and mental attributes, etc. with every other individual. To the extent that a person deals realistically with his

---

[38]Reuel L. Howe, *The Creative Years* (Greenwich, CO: Seabury Press, 1959), pp. 206-207. Howe expands on Tillich's view at this point.

[39]Paul Tillich, *The Eternal Now* (New York: Charles Scribner's Sons, 1963), p. 158.

physical limitations, his finiteness, and operates within the scope of his limitations and not those of another person, he will actualize his own potentialities and so be mature.

If man recognizes himself as being free and not merely having freedom, he can separate his worth as a person from the restrictions on his being so as to transcend them through the Power of *agape* love. Only *agape* love takes this element of man's being seriously into consideration and loves him with all of his finitude. Although a person with spinal cord injury is severely limited in his body and future prospects, and may be unable to alter the circumstances of his existence, he can nevertheless determine or choose his attitude towards his physical condition. The power of self-transcendent love alone makes this possible when it communicates to a person that he is still loved and related to the Ground of Being and Love, regardless of his disability, even to the point of death.

2) At this point Tillich's second understanding of maturity as an ambiguous state of being which he terms "blessedness" becomes relevant. This implies a different level of maturity in which man attains a condition or quality of life in which inner conflicts surrounding freedom are resolved, at least partially. Having struggled through the excruciating realization of his own impending death, he feels fulfilled and is more at peace with himself. The self is perceived in a new way because he is willing to accept the affirmation of himself through divine love. This "blessedness," which is possible not only at death's door but also in the present as the polarities of

being are united, even though temporarily, approximates quite closely Tillich's concept of "the essentialization of life." Actualization and essentialization are represented as two points along a continuous line stretching from immaturity to fullest maturity. Man's essentialization in union with the Divine Life is a measure of his own maturity.

The central feature, therefore, of Tillich's concept of maturity is *agape* love. A person's maturity or immaturity is gauged according to the extent of his acceptance and actualization of this love in his own life and in all his relationships with his world. It also measures the amount of courage he has to risk the awareness of his finitude in positive tension with his infinite potentialities.

As a partially achievable and ambiguous state, maturity expresses the quality of Eternal Life, as life confronting death. Man is offered both present and future hope. His entire life is involved in the maturation process of becoming his true self. Because the quality of man's life is greatly enriched by the intervention of *agape* love into his life and history, human, psychological or emotional development is merely one aspect of a wider perspective of man and his potentials. Involvement in the process of becoming mature means awareness of the possibility of "new being" and salvation within the "now" of life. Man can also become aware of himself as a participant in the community of life and love. To experience the power of the "New Being" in Love and acceptance is to know the Power of God revealed in Jesus as the Christ, the bearer of the New Being who is the example of man's hope and the revealer of the *agape* life-style which is

authentic maturity.

2. Heath's Categories of Maturity

Heath defines maturity thus:

> The maturing person becomes more stable, organized, integrated, allocentric, autonomous, and more of his internal and external experiences become symbolized and available to awareness.[40]

Adopting a psychological approach, he establishes five genotypic developmental dimensions as essential for a mature person. They are: (1) increased emotional and self-image stability[41] (2) consistency and integration[42] (3) allocentrism and (4) an increased awareness and expressive symbolization of internal and external experiences and (5) autonomy.

In this study, these categories will be clarified, dimension by dimension, in the context of Tillich's life processes, to demonstrate how the latter illustrate the psychological implications in onto-theological terms. The correlation between Tillich's onto-theological dimensions of maturity and Heath's psychological dimensions support strongly the application of Tillich's ontological polarities to a broader understanding of man's psychological dilemma.

Heath's increased emotional and self-image stability belongs to the mature person who can maintain his identity over a period of

---

[40]Douglas H. Heath, *Explorations of Maturity* (New York: Appleton-Century-Crofts, 1965), p. 35.

[41]*Ibid.*, pp. 28-29.

[42]*Ibid.*, p. 35.

time (denoting the element of continuity), while resisting and recovering from any disorganizing effects. His behavior is marked by less impulsiveness and forced determination and is controlled by more cognitive types of structures.[43] From Tillich's perspective, Heath's emotional and self-image stability imply the actualizing of the polarities of freedom and destiny, dynamics and form. All the polarities, along with the life processes, occur simultaneously in man, even though one polarity or process may be isolated and identified as primary in any given context. While a person has feelings as part of the givenness of his individual identity, he is also free to transcend those emotions by his capacity to choose responsible ways of expressing them. The knowledge that he is loved as a unique, individual, unexchangeable, but finite person, frees him from his and others' identification of his worth with his emotions. These characteristics of his "person-ness" point to man's awareness of his "is-ness" which is individualized and unique. In this respect, the individualization aspect of the individualization-participation polarity is crucial. The freedom which he can experience means that, even if and when a person is upset emotionally, he will not be overwhelmed and devastated, because others are not evaluating him solely and conditionally on the basis of his behavioral responses. And yet he knows that he is responsible for his own behaviors, and his reactions and responses to persons and situations. His awareness of being accepted as worthful by others or by God means

---

[43] *Ibid.*, pp. 28-29.

that he is not obliged to concentrate on possible rejection, but can consider his feelings in the particular setting. When there is conflict between two persons, each can now ask himself: Why am I angry? Is it because I feel that my intentions and value have not been appreciated and recognized by the other person? But am I appreciating and recognizing *his* value and intentions? When each person is aware that the primary concern is restoration to a relationship of unconditional love, he needs to work out alternative ways of responding to the other person. This can be a liberating experience for both and can amount to their salvation. Although an emotion is different from an attitude, nevertheless it indicates the attitude or perception which is held at the time. And so each person is aware that his feelings reflect attitudes which may be linked with feeling possibly unacknowledged, unappreciated, even unloved. Yet, when the assurance of unconditional love is present in the relationship and is supported by empathetic listening, the acknowledgment of intentions and the desire for the restoration of the loving mutual relationship on the part of each person, then the essential element of change can be facilitated. In this way, the potentially disintegrating threats of emotional responses have been subordinated to the transcendent cognitive response, namely, the awareness by an individual of his freedom to disidentify his worthfulness, as a person, from his self-perception and emotions.

Similarly, in considering issues of self-image and threatened identity, the polarity of dynamics and form is important. This polarity is effective in the life process of self-creativity and self-

destructiveness. A person experiences dynamics and form through vitality and intentionality. Vitality is the power which keeps a living being alive and growing. It is not merely pure life power, but impels beyond itself, i.e. transcends itself to create new forms. Man's thrust for change causes him to reach beyond his grasp, in self-transcendence, to discover a new form which conserves but also enriches and enlarges those structures, values and thought systems with which his self has become identified. Once again, the concept of love is crucial. A person's ignorance or non-acceptance of his self-affirmation may lead him to identify himself with a certain form, i.e. a specific self-image because he assumes that others will love him only if he conforms to their expectations in attitudes, behavior, appearance, etc. Whether he becomes rigidly conformist or rebelliously unconventional, without direction or guidance of rules, the result will be the same, viz. a separation of dynamics and form in which no stable identity is achieved. In the case of rigid conformity, the identity is too stable, but it is not really an expression of the person's own true being. Either approach leads to self-destruction instead of self-creativity. It is only when a person discovers himself as loved, apart from any assumed demand for a particular identity or self-image, that he can be relaxed, flexible, creative and open to change. Because his self-image is no longer bound to supporting some sort of pretense or facade about his abilities and their limitations, he is free to change. Such change is not tantamount to a loss of self, but involves merely an adjustment in attitudes, feelings and roles which he, as an

affirmed and loved individual, is free to alter. Simultaneously, if he is loved, he is also free to become himself, a growing, changing person who can risk himself to the aging process.

Consistency and integration mean for Heath that the mature person is an open system, who continually looks for and obtains new stimulation as a welcome gift to his inherent desire for growth.[44]

In this dimension, several of Tillich's polarities and life processes are involved. With reference to the life processes of self-integration and self-creativity, interaction exists between both individualization and participation, and between dynamics and form. The characteristics of self-integration are centeredness, responsibility and love, and its function can be understood from the perspective of the individualization-participation polarity. Only a highly-centered self can become an integrated self. The maintenance of centeredness is achieved by creating new centers beyond the circumference of its own self-identity, but in such a way as to preserve continuity of the self which changes. Here an interaction of the self with the world is implied, yet without loss of the self or its centeredness. Centeredness is individualization which has already been affirmed. The individual is a centered self in relation to other centered selves in community. Therefore, the movement or thrust towards individualization continues to be in positive tension with participation.

In moral responsibility, which is another aspect of self-integration, the decision-making area is crucial. Although a person

---

[44] *Ibid.*, p. 29.

may be cognizant of moral law and wish to fulfill it, he also recognizes that such fulfillment may be ambiguous. The self-integrated individual is prepared to risk failure in making a partially good decision because he knows that he is accepted and affirmed despite his partial knowledge. Recognizing that every decision excludes other possibilities, the self-integrated person makes decisions to the best of his ability because he lives out of the love that makes courage a reality. In this action, he confronts his own finiteness and potential non-being with courage and becomes capable of loving others.

It is through the *agape* quality of love that the self-integrated individual receives the power of his being and is able to offer this to others. Only *agape* love enables him to share with others in community without identification to the point of absorption or the loss of his identity as a unique and individual person. In turn, the self-integrated person does not demand that others conform to his viewpoint before they are accepted as persons in their own right. In the absence of love and justice, depersonalization and manipulation occur inevitably which are complete negations of Martin Buber's I-Thou concept, in which a person is treated as a subject, a Thou, by other centered, individualized persons, and not as an object, an It. Love produces the courage to increase individuation and relatedness, which in turn increases creativity and transcendence.

Tillich understands the desire for growth, excitement, and realization of potentials in the context of the polarity of dynamics and form and the life process of self-creativity. Among man's inherent

characteristics is the desire to actualize his growth potentials merely because he possesses them. Failure to actualize them leads to their atrophy, while a decision not to actualize any potential arises primarily from fear of failure as experienced through the expected and projected rejection of others, which is the outcome of neurotic anxiety, and in some cases, compulsive behavior. In the mature person, growth, change, and discovery of the new are not undertaken to gratify others in order to earn their affirmation and approval by attempting to measure up to their expectations, but merely because change constitutes an expression of his life in the world.

Allocentrism and an increased awareness and expressive symbolization of internal and external experiences, which are the third and fourth dimensions of Heath's psychological maturity, seem to be interrelated. In contrast to the immature person who is almost completely autocentric, the mature person is more allocentric in that his thought processes are more directed towards reality and less influenced by drives and emotions. He becomes increasingly aware of himself and the determining factors in his world and destiny and of other persons' perception of him. Loving and caring relationships with others become central in his life. His peers rate him as empathetic, altruistic and thoughtful of others, and his own needs and the demands of others are more in balance.[45]

Like Tillich, Heath recognizes the important fact that maturity involves accuracy in perceiving and interpreting reality and

---

[45] *Ibid.*, p. 335.

that the relationship between the person perceiving and the perceived person or thing, either world or community, is essential for the actualization of human nature.

Any compulsiveness or pretense directed towards concealing finitude for fear of being rejected, if limitations are disclosed, tends to seal off large areas of experience. At this point, Tillich recognizes that perception is basically a matter of attitude. The immature person is so afraid the world will reject him that he assumes rejection, projecting it onto his perception of others and the world. This projection then becomes his perception of reality. Feared rejection, and other experiences which do not match his attitudinal constructs, will either be abandoned or will create crises. He may then find himself experiencing what Tillich terms a conflict of ultimate concerns in which growth and change are frequently curtailed.[46]

But the mature person, because he is loved and accepts his acceptance, has courage to perceive reality more obviously. Because of his attitude of trust he can see the world differently and, although he may not assume that every experience will confirm his worth, he is prepared to take a risk. The more he does this, the more opportunities will be available to him for confirming experience. His attitude of courage will be increasingly reinforced in proportion to the amount of non-being he assimilates into his being. Even if he sometimes suffers negative reactions to his emotional expressions, his thoughts and his work, he can transcend these through the larger spiritual

---

[46]Tillich, *Systematic Theology*, I, 146.

self-affirmation.

Like Tillich, Heath also recognizes the importance of keeping a balance between autocentrism and allocentrism, i.e. between the individual's needs and those of others. Tillich's polarity of individualization and participation is fitting here. Tillich is aware that basically life starts and continues in a largely self-centered or, to use Heath's term, autocentric way. This is not inappropriate or undesirable, since it is man's natural self-affirmation to prize his own worth very highly. But his own worth cannot merely be realized in and of himself. It is in the nature of man to need others just as they need him. Because his being is actualized only when he is both a giver and a receiver, he is truly a person who must belong to a community. Self-affirming by nature, it is natural for him to receive, but the law of his own being demands that he give to others loving them in exactly the same measure as he loves himself. The enigmatic outcome is that in loving others, he truly loves himself, for through loving, he affirms the basic nature of his own being. Tillich regards *agape* not as an emotion, although it may use feelings to convey its meaning. The person who loves without conditions is aware of a new reality which transcends the drives or emotions.

Autonomy is the fifth dimension of Heath's concept of psychological maturity. Here the mature person "is not as immediately controlled or determined by his immediate environment or his motivational state or his earlier childhood history."[47] The dynamic struggle which

---

[47]Heath, p. 35.

occurs in the concept of autonomy constitutes Tillich's polarity of freedom and destiny, the life process of self-transcendence. In the mature person, independence and freedom predominate over dependence (or conformity) and destiny. The autonomous and independent person is not unrelated to his environment, but in the process of growth he can come to the place where he is relatively inter-dependent. While it is acknowledged that the beginning of life involves total dependence upon its environment, as represented by the embryo which is dependent on the mother's womb, the innate thrust of its nature is towards freedom from complete dependence, i.e. towards independence. In asserting his independence, man actualizes his freedom which he experiences as deliberation, decision and responsibility. Deliberation indicates a centered self who weighs arguments and motives and reacts as a unity to the struggle of motives. In decision-making, the centered self has put aside all other possibilities, while standing beyond the decision. The self is not its decisions, but rather transcends them. Through this feeling of distancing, the self can assume responsibility for its own decisions.

Because a person's freedom is not absolute, the assertion of his freedom may conflict with another person's freedom. In this sense, destiny, in the form of restrictions on his freedom, is represented in that other person. The other limits on his freedom, as destiny, include his body, mind, health, imagination, abilities, and often his past experiences. For the immature man, confrontation by these restrictions on his freedom may be an agonizing experience in which

he anticipates rejection because of them. In such event, he may tend to reject his limitations and either deny them or withdraw. This can be precisely the case in spinal cord injury. The result of both actions can be self-destructive and disastrous. Only the *agape* type of love can help a person to accept responsibility for his freedom. This means that the mature person must face his own and others' behavior and abide by the results of his decisions and the use of his freedom. When an individual accepts the unconditional affirmation of his being, so that his worth is not destroyed, even if he has been irresponsible, he receives the power and courage to risk further actualization of his freedom.

Insofar as a person assumes increasing responsibility for his freedom and thus becomes less determined by his environment, he develops maturity. The environment's deterministic and compulsive control over man creates in him a fear of rejection if he fails to conform to the limiting circumstances or expectations of that particular environment. This is very true when the environment is interpreted as the cultural, racial or national setting which a person enters by birth and in which he may be expected to remain. Maturity therefore represents man's acceptance of his freedom and its limitations. Through such acceptance he can occasionally transcend his environmental limitations in expressing love towards others.

3. Immaturity versus Maturity within the Life Processes

In the foregoing section, the actualization of *agape* love has

been advanced as the focus and central unifying feature of maturity. Acceptance of this *agape* love has been suggested as the determining factor in man's courageous uniting of the ontological polarities in his being. The assumption, therefore, is that the lack of love or its non-acceptance, experienced as fear of rejection by others and life itself, leads to the failure to take the courageous risk implied in the realization of potentials. Consequently, the person experiences a reduced self-expression and a shrunken world emerges characterized by immaturity, or a lack of continuing development of his potentials. The immature man cuts himself off from the dynamic possibilities inherent in the interaction between individualization and participation, dynamics and form and freedom and destiny.

In the Person-World Reviews to be presented in Chapter V and in the results of the S.I.Q. and other inventories reference will be made, where applicable, to cases illustrating the unity of the ontological polarities and integration of the life processes, defined as maturity, and the disunity of the polarities and disruption of the life processes, defined as immaturity.

D. EXISTENCE AND LOVE

Up to this point, besides an examination of Tillich's analysis of human existence, the main focus of this dissertation has been to indicate the importance for the individual with spinal cord injury of developing his maturity towards self-fulfillment as a person. A first prerequisite in this process has been affirmation of self by others

and affirmation as a being of worth capable of actualizing one's potential. The second prerequisite implies that to be ongoing and effective in all areas of life, the person's growth must take place in existing and future interpersonal relationships in the wider community, which may involve changes of attitude and behavior and of perceptions of self and others.

The key or bridge between self-awareness and the need for relatedness, as they apply specifically to the existential situation of the person with spinal cord injury, seems to be found and summed up in the need of the person to receive and accept love and affirmation of himself from other persons. The hypothesis (see page 5) upon which this study is founded asserts that as a person with spinal cord injury is exposed to the essential message of the Christian Gospel and responds to it positively, he thereby allows others who may be the vehicles of the essential message to affirm him as a person of worth who belongs to the community and can take his rightful place in the whole human enterprise. This gives him the courage to face his disability realistically and to learn to live creatively as a person of faith, hope and love, growing in maturity and enjoying adequate and satisfying interpersonal relationships at all levels.

It must be pointed out, however, that the disabled person does not need to subscribe to any of the tenets of the Christian faith in order for this to happen. In other words, the possibility is open to all persons, irrespective of race, color or creed. What, then, is the essential message? Obviously, a "scientific" definition would

be difficult to advance in the same way as the "scientific" measurement of man's basic need to love and be loved would pose problems. As has been shown so far, these are matters which can be described experientially rather than proved conclusively. Briefly, the important content of the Christian Gospel is that God as the Ultimate Ground of Being (known as Ultimate Concern, as the Power of Being and Power of Love and supremely revealed in Jesus Christ as the New Being) takes man seriously in his humanity: man is both affirmed and confronted in the totality of his being. The essence of the Christian Good News is the approach of God to humanity which takes men and women seriously as persons in all predicaments, irrespective of their circumstances. This approach of caring concern which is at the very basis of affirmation and Christian love is exemplified supremely in the Incarnation--the total ministry of Jesus of Nazareth, as the bearer of the New Being.

Reference has been made in several places already to the importance of the concept of love and its place in the comprehensive rehabilitation of the irreversibly physically disabled. Paul Tillich has made a substantial contribution in elucidating this concept in the areas of man's self-acceptance and need for inter-relatedness with other human beings. Before attempting to define the concept and to examine its application to the study, some more specific comments concerning the disunity of the ontological polarities and disruption of the life processes in man need to be made.

1. Disunity of Ontological Polarities and Disruption of Life Processes

With the sudden and unexpected onset of trauma, persons with

spinal cord injury are in real danger of experiencing an extreme loss of centeredness which may also be described as a potential loss of self-world relationship. There is an intensified need for acknowledgment, appreciation and acceptance of them as unique individuals because and in spite of their finitude, all of which must come from their immediate environment, including family, peers, school, work context, etc. They need to be accepted as worthful, growing, unexchangeable persons. At the same time, the possibility exists always of a conflict between their thrust towards increasing individuality and autonomy and their need to belong, but without the pressure of conformity. The threat of loss of identity and of the self as centered combined with anticipated loneliness, isolation and rejection can be very real to them. Because they need the positive stimulus of the immediate environment, meaningful human relationships become very important in counteracting any tendency towards any negative preoccupation with their own world and experience. An enlarged scope or world enables them to envision other alternatives and to make responsible decisions so as not to fall prey to self-disintegration.

Only the *agape* quality of love can provide within the primary environment the atmosphere and attitude for their acceptance and affirmation, not rejection, as persons with massive disability. With the acceptance of this love, the disabled realizes that he is no longer, if he ever was, judged on the basis of performance, awkwardness or appearance, etc. He begins to relax and concentrate on the center

of his being, discovering his own centeredness and expanding his perceptual field to incorporate the centers and worlds of other human beings. The experience of this *agape* love creates a new attitude in the person receiving it. This in turn creates a new environment of affirmation in which it is possible for the receiver to become a giver and in which others are loved as he loves himself. The increased love of his own world means that the person with spinal cord injury increases his intimacy with that world and requires that, on any level of relating, sexual, psychological or otherwise, he love another person's uniqueness and worth as he loves his own. Through the expression of this *agape* love alone, the life process becomes self-integrative.

The opposite of this positive movement towards maturity is self-destruction arising from the inappropriate and inflexible interaction of the polarity of dynamics and form. If the person with spinal cord injury affirms his own being as a growing, changing being in the world in the process of experimentation and seeking the actualization of his own identity, then he is involved in changing his form dynamically. Denial of the necessary connection of his form, i.e. his body, to the life-giving potentials surrounding him, e.g. outside stimuli, proper health maintenance, etc., will result in his decision to restrict his form. This means a severance of the self as the meaningful center of his being from his body and mind through psychological or even compulsive preoccupation with his condition, which indicates a negative movement towards self-destruction. Preoccupation with one's condition creates a sort of moratorium on one's perception of the

necessity for change, e.g. relinquishing the role of an invalid which, in the case of spinal cord injury is an essential transition stage from being "sick" to "different." In the case of the person with disability this means often a tendency towards denial of reality, euphoria, withdrawal and a desperate holding on to and protecting his present form for fear of losing it. Any threatened loss of present form is perceived as a loss of self. In this respect, there is a disregard of the fact that no being is static; a person is either in the process of moving toward the actualization of his potentiality or away from it. In order to effect change, so that the person becomes aware of his environment, a disidentification of the self from its particular form fixated in the disabled stereotype is necessary. Along with this goes a need for listening to and acknowledging other more potentially creative alternatives.

Once again, only *agape* love can break the self-destructive tendencies produced by anxiety, negative dependency and rigidity so that the person with disability can become more open to his environment and his potentials. With this influence alone can he risk change without losing his centeredness and express his life in new and exciting ways without forfeiting the sanctity of his person or losing a consistency and continuity which envelops both his past and his present. It is the realization that he has reached a certain stage in his life and can accept his state and that all is well.

When the person makes ultimate those persons, objects and values which are not in fact ultimate, he undervalues and objectifies

both himself and others in such a way that they become used, manipulated and humiliated. This turning of the holiness of interpersonal relationships into a depersonalized thing, together with devaluation of the self and other selves, produces shame, degradation, resentment and anger and is known as self-profanization. It is a case of a person having used his essential dignity and freedom in relation to someone else in a negative rather than a positive way in a desperate attempt to find security in the midst of life's cataclysmic changes and uncertainties. Its only outcome is the feeling of emptiness and void through having capitulated to that which is not ultimate.

The separation of freedom from destiny causes new problems. While unrestricted freedom produces willfulness or arbitrary conduct, destiny separated from freedom becomes compulsiveness. In the case of the person with spinal cord injury he may feel he has to prove himself beyond his limitations in order to be acceptable to others. True personal identity can be established only when the poles are distinct. Compulsiveness indicates that the person who feels driven by necessity is already feeling unloved and rejected. It is an attempt on his part to conceal his finiteness for fear that he will be rejected if his weaknesses and imperfections are known. Only love as acceptance of the person with disability who persists in his denial of the reality of his condition will break his compulsive behavior and free him to take responsibility for doing something positive about it.

But freedom is also limited by destiny. In the case of a person with permanent disability this means mainly the finite

limitations of skills, health, strength, life expectancy and bodily changes all of which form part of the natural disintegration of the life process, but with more intensification because of the particular condition. Only the existence of unconditional love as affirmation from others allows freedom and destiny to be held in positive tension and confronts a person with disability who persists in denying his finitude and in manipulating others through negative dependency to be confronted with the results of his irresponsible behavior. This type of love, which reminds him that he is accepted in spite of his actions and frees him to act responsibly, is not just sentimental, cheap grace but real caring concern for him as a person. Only as the individual's freedom and responsibility are affirmed together can he begin to love himself and others and change his life-orientation from self-profanization to self-transcendence.[48]

2. Tillich's Ontology of Love and the Essential Message of the Christian Gospel

Tillich bases his ontology of love on the following concepts:

(1) love is a unity in which every quality of love shares something in common with the others.

(2) love is one of the elements of the real which is constitutive of everything that is.

(3) love is a movement of a whole being, i.e. an attitude rather than an emotion.

As the fundamental moving power of being and life, it is best

---

[48]See also William A. Sadler, Jr., *Existence and Love* (New York: Charles Scribner's Sons, 1969).

described as a thrust, a drive or an urge toward the reunion of that which is alienated or separated.

As love forms a unity, i.e. is one, it must be understood solely as different qualities of one nature and not in terms of some typology. The four qualities recognized by Tillich are: (a) *libido* (epithymia)--the movement of the needy toward that which fulfills the need; (b) *philia*--the movement of the equal toward union with the equal; (c) *eros*--the movement of that which is lower in power and meaning to that which is higher. All these three contain the element of desire, but this does not contradict the created goodness of being, since separation and the longing for reunion belong to the essential nature of creaturely life. In addition, there exists *agape* which Tillich describes as

> a form of love which transcends these, namely, the desire for the fulfillment of the longing of the other being, the longing for his ultimate fulfillment.[49]

Agape is that form of love mentioned in the New Testament as divine love in which all others are fulfilled and yet transcended. In contrast to all the other qualities of love which are conditioned and affirm another person on the basis of passion or sympathy, attraction or repulsion, *agape* love alone is unconditional. It does not place attitudes, behavior or values as pre-conditions of affirming the other person, but rather affirms him as being, quite apart from any pleasant or unpleasant, higher or lower aspects. Love as *agape* "unites the lover and the beloved because of the image of fulfillment which God

---

[49]Tillich, *Systematic Theology*, I, 280.

has of both."[50]

Whereas *philia* is preferential, *agape* is universal and not exclusive. No one is preferred and no one with whom a concrete relationship is technically viable, i.e. a "neighbor" is excluded.[51] Moreover, *agape* suffers, forgives, and accepts the other despite resistance and negation. While doubts may be raised as to the human possibility of love as *agape*, Tillich advances it as being ultimately the symbol of God's love for man, and the divine commandment in interpersonal relationships, even if the neighbor is regarded as an enemy.[52] *Agape* alone motivates by giving what it demands, not as law, but rather as grace. *Agape* as grace is a free gift given without the receiver having to earn or merit it or having to meet prior qualifications or conditions. The giving is an expression of the nature of the giver and a declaration of his own being. Because it is needed, it is given to all persons equally.

To summarize, because man does not wish to remain in a state of estrangement or separation from other persons, he may be said to love for his own sake. Tillich only accepts the term "self-love" to mean loving oneself and one's world as an expression of the infinite or divine with whom one desires reunion. This means seeing in all finite being its potential of the infinite. Therefore it means a loving of God and other persons through oneself.[53] Man desires reunion and re-establishment of community with others because that constitutes

---

[50] *Ibid.*

[51] *Ibid.*

[52] *Ibid.*, III, 274.

[53] *Ibid.*, II, 48.

the nature of his own being. As stated previously in the hypothesis and elsewhere, man is created to love and be loved.

Self-acceptance, which can be considered from both human and divine perspectives, provides the key to the power which enables man to risk his very being in *agape* love. A correlation exists between human love and divine love. Man's first experience of love occurs within the context of his particular social environment, e.g. his family. From this he is enabled to trust the ontological basis of love in the Ground of all Being, or the religious-moral environment.[54] God's love of man is the ground for man's acceptance of his own being and the source of his love for other human beings.

From the divine standpoint, self-acceptance refers to God's love for his creatures as beings in which He affirms that they are accepted and are precious. It is God's offer of love as *agape* to a finite human being which recognizes and accepts man despite his finitude. This love was incarnate in the man Jesus of Nazareth who is the Christ and the bearer of the New Being. He is God-for-us and for everything created. This is the essential story of the Good News--the essential message of the Christian faith.

Man, as a self-conscious being, is aware that he is restricted by space, time, creaturely contingency and the possible loss of self-identity in the process of change. His basic ontological nature, i.e.

---

[54]See Erikson, *Identity and the Life Cycle*, where basic trust is established as the fundamental task of infancy, and other implications concerning religious faith are discussed.

as separated being thrusting toward reunion by means of love, is constantly threatened by finitude and also with possible rejection. This rejection is expressed as loss of potentials understood as loss of self and as loss of his world understood as loss of other human beings. The hard questions which present themselves to man are: How can I be loved if I never quite live up to my created abilities, or if I fail to reach the expectations of significant others or if I make mistakes? Only divine acceptance of man given as *agape* love makes human acceptance possible and makes allowance for man's being as finite person, accepting him despite his limitations. The constant interrelation between divine acceptance and human acceptance by others implies the presence of the Power of Being in every relationship where one person loves another unconditionally with the quality of *agape* love.

Man's acceptance of God's acceptance and its incorporation into his being provides the basis for his growth outwards to confront his own finitude and to build creatively on his potentials. The type of spiritual self-affirmation which is exemplified supremely in Jesus as the Christ, is available for all men. The essential message of the Christian Good News is not only its universality, but also the declaration that it is based on an ontic self-love of a person's own being and on the courage to affirm himself despite threats to his being and increasing anxieties.

Viewed humanly, self-acceptance is related to man's perception of others' acknowledgment and appreciation of his worth as a person. But if he perceives or assumes repeatedly that others are identifying

his worth as a person with his bodily appearance, his attitudes, values or behavior or some other finite expression of his being, he will automatically react negatively in anxiety and anger as perceived rejection. The logical end of this is that he feels completely unacceptable, even to the extent that he does not exist to another or others, especially those significant persons in his world.

Although anxiety, which Tillich defines as man's awareness of his own finitude, is normal to human existence, man is faced with either giving way to despair or living courageously. The person who despairs seeks to avoid his inner conflict with himself and the feeling of hopelessness and helplessness, and in the case of the irreversibly physically disabled this often takes the expression of withdrawal, euphoria or denial of the condition.

If he adopts the second choice of affirming himself despite the frightening threat of non-being, experienced as existential anxiety, and of accepting the insecurities, uncertainties and misgivings about his finiteness, then he follows the way of the courage to be himself. In doing this, he recognizes the power of anxiety and accepts it, receiving it into his being but not allowing himself to be overwhelmed by it.

This is possible only when a person receives the Power of Being as the Power of Love and experiences it in many forms as a spiritual presence which grasps him in what Tillich terms an "ecstatic experience."[55] The person who suffers the trauma of irreversible

---

[55]Tillich, *Systematic Theology*, III, 115.

physical disability faces the threat and power of non-being and in coming close to death becomes consciously aware of the gift of his life. In experiencing the tender, supportive, healing Power of Love in this extremity, he is moved to respond joyfully and thankfully to God's recognition of his preciousness and to his caring concern. But the person with spinal cord injury may also experience this Power of Love as a transforming and shaking confrontation which will call in question his whole life-style and self-destructive behavior, if he is denying his condition as a finite human being. He is then challenged to take realistic steps to affirm his existence in more life-sustaining ways. In each case the Power of Being as the Power of Love motivates him to take action and make decisions. It compels him to take the courageous risk of meeting the various existential anxieties in his life such as potential death, meaninglessness, fate and guilt, which are all interrelated. Only by so doing can he become the person he knows he is essentially.

Man's acceptance of God's unconditional love means that the Power of Being and Love is God's final word of victory over death, fate and guilt. The power of acceptance which is contained in it is expressed in the Protestant message whereby man is accepted (justified) not through becoming acceptable but rather by grace, as a gift through faith which means believing in and accepting the gift. Only by accepting the offer of unconditional *agape* love can man be motivated to risk becoming the self-integrative, self-creative and self-transcendent being he is.

From the foregoing comments, it will be seen that courage-to-be and man's salvation are closely related. Indeed, salvation means to be: it means to find unity where once there was estrangement and fragmentation; it means the reconciling of God and man, man and his world. Salvation means a reclamation of the old and a bringing in of the New, in which the ultimate meaning of existence is revealed and fulfilled. And so, through participation in the New Being, through the acceptance of the New Being, and through being transformed by the New Being, man is given his salvation, and simultaneously, his capacity to love and be loved, to hope and to enter with courage into the human predicament.

PART II

CHAPTER III

SPINAL CORD INJURY AS A HUMAN PHENOMENON

The person who has sustained a spinal cord injury or who has been permanently disabled through disease affecting the spinal cord has been confronted with an extreme crisis in his life which brings with it grave consequences, the most notable of which is a sudden tragic set of limitations on the victim's life. The catastrophe, in whatever form, can bring to an end instantaneously and once and for all not merely future expectations, but a reasonably stable manner of living as well.

Such an extreme existential situation can reduce a person to varying degrees of immobility which will improve or deteriorate according to the degree of success of corrective procedures and therapy following the initial trauma. In any case, the man or woman concerned becomes a "wheelchair" person in the eyes of most of the world. The different aspects of this human phenomenon are now to be considered.

A. THE PHYSIOLOGICAL CONDITION[1]

A considerable amount of ignorance and misunderstanding exists

---

[1]For some of the detail in this section, reference has been made to information in *Patient Handbook for the Regional Spinal Cord Injury Rehabilitation Center of Rancho Los Amigos Hospital, Downey, California* (Los Angeles: Oxford Press, 1968), pp. 1-2. See also Dan H. McEver, "Pastoral Care of the Spinal Cord Injury Patient," *Pastoral Psychology*, XXIII:221 (February 1972), 47-49.

concerning the etiology and anatomical description of spinal cord injury in the minds of the general public and even among members of the medical and nursing professions.

The spinal cord consists of a bundle of nerves linking the brain to the individual's skin, muscles and internal organs. Approximately one centimeter in diameter, it is enclosed in a canal which passes through the bones of the back called the vertebrae. The vertebrae number twenty-four segments altogether, divided into three groups: (1) seven segments located in the neck region referred to as the C (cervical) vertebrae, (2) twelve segments in the back of the chest known as the T (thoracic) vertebrae and (3) five large segments in the low back called L (lumbar) vertebrae. Each vertebra is classified by using the letter of the region and a descending number within that group, e.g., C^5 or L^2.

The spinal cord is often injured when a vertebra is dislocated or fractured in the spine itself. Severance of the spinal cord is like cutting the electric conduit connecting the power station with the lights in a home. The circuit will be broken completely. No way has yet been discovered to repair a severed cord so that it will function again. Severance of the cord means that the parts of the body below the lesion are separated from their connection with the brain. If the cord is only partially cut, only part of sensation and strength below the injury is lost. Occasionally the function of the cord is interrupted temporarily through bleeding and swelling pressing on it. Sometimes, when the swelling subsides or is removed by a

surgeon, the cord will recover and start to function again. Involuntary movement of muscles may occur, through spasms which are a type of reflex action, even when the cord is not functioning. Two nerves, called roots, leave each side of the cord between the vertebrae; one root carrying sensation from the skin and the other controlling muscle movement. Therefore, when a stimulus enters through the sensory nerve to the spinal cord and back out to the muscle, this may precipitate a reflex arc reaction and cause uncontrolled movement.[2] At times, these spasms present such problems for the patient that a surgical procedure, a neurectomy, is performed to cut the nerve to the muscle.[3]

In cases of permanent damage to the cord, the level of the lesion is extremely important, because the higher it is, the less movement the individual will have. If the injury is at C^4 and is complete, the diaphragm alone remains functional and the person requires complete nursing and other care. An injury at level C^5 means that the biceps and shoulder muscles are preserved. This will necessitate nursing care including being lifted and dressed, but the person should expect eventually to learn to dress and perform ablutions and personal grooming and feeding by using special devices. A person with a C^6 lesion retains the control of enough muscles, including wrists and extensors, to become in time independent in a wheelchair. With

---

[2]Howard A. Rusk, *Primer for Paraplegics and Quadriplegics* (New York: Institute of Physical Medicine and Rehabilitation, New York University Medical Center, 1960), p. 4.

[3]*Ibid.*, p. 8.

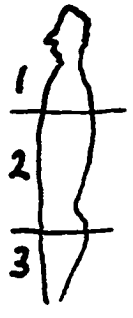
reasonable intelligence and good motivation, his chances are fair that he can be trained for employment and return to society as a useful citizen. Any person with a cervical lesion below this level ought to be able to become independent in all activities from a wheelchair with even greater facility because he will have some use of finger and thumb muscles. As arms and hands are not affected by lesions in the lumbar and thoracic regions, the person should have little difficulty in becoming independent in a wheelchair. Consequently, a person with an injury below the cervical level is referred to as a paraplegic, while the person with an injury in the cervical area is called a quadriplegic.[4]

Spinal cord injury is generally classified according to medical diagnoses into the four main categories of traumatic, neoplastic, vascular and infection. It is interesting to note that for the purposes of sport, the International Paralympics Conference and the Southern California Wheelchair Basketball Conference have adopted a player classification with numerical values or factors for each class in order to balance team members in competition.[5]

---

[4]See Florence I. Mahoney, "Rehabilitation of Spinal Cord Injured Patients," *Maryland State Medical Journal*, XVIII (October 1969), 115.

[5]



Class I: Complete spinal paraplegia at T^9 or above or comparable disability where there is a total loss of muscular function originating at T^9 or above.

Class II: Complete spinal paraplegia at T^{10} or below or comparable disability where there is a significant loss of muscular function of hips and thighs.

Class III: All other disabilities.

The most serious physical problems resulting from the paralyzing effects of spinal cord injury relate to the genitourinary system, respiration, pressure sores or decubitus ulcers (bed-sores) and muscle contractures. Interference with rehabilitation goals arises most commonly from complications with urinary tract infections and decubiti. Mortality among paraplegic British soldiers in World War I was estimated at 80 per cent, of which 47 per cent deaths occurred in the first six weeks after the injury. Complications of urinary tract infections were among the principal causes of death. Although some still today die from such infections, antibacterial therapy has increased the survival rate of spinal cord injury patients considerably.[6]

Severance of the cord deprives both male and female sex organs of sensation, but the trauma does not make sexual relations impossible for each person. The individual's reaction and attitude in this area is essentially idiosyncratic. In any evaluation of sexual limitation following spinal cord injury, it is obvious that a person's self-image and ego suffer a great blow.[7] Since his body is physically intact, he tries to maintain an intact body image as well.[8] Unlike the amputee,

---

These classes comprise traumatic, post-poliomyelitis, osteogenesis imperfectus and spina bifida paraplegics.

[6]See Mahoney, pp. 113 and 115. Also Lea L. Tuck, "Bladder and Bowel Retra," *American Journal of Nursing*, LXX:11 (November 1970), 2391-93.

[7]See Wachs H. Zaks, "Studies of Body Image in Men with Spinal Cord Injury," *Journal of Nervous Mental Disorders*, CXXXI (1960), 121-27.

[8]Alfred D. Mueller, "Psychological Factors in Rehabilitation of Paraplegic Patients," *Archives of Physical Medicine and Rehabilitation*, XLIII (April 1962), 151-59.

who can see that a part of his body is missing, the paraplegic or quadriplegic can see and touch his paralyzed limbs. The realization that he is paralyzed and has lost normal functions of his sexual organs and bowel and bladder control may cause anxiety, denial, and depression.

For men, after injury, the physiological aspects of the sex act are most important since erection and ejaculation are affected by the damaged sympathetic and parasympathetic systems. Priapism, i.e., persistent abnormal erection of the penis, usually without sexual desire, which occurs in about ten per cent of men with spinal cord injuries, is uncontrollable and can become an extremely embarrassing social problem. Studies reveal that approximately 66 per cent to 75 per cent of all cord-injured males have erections, but only one-third of these are able to maintain the erection long enough to complete intercourse. Orgasm is relatively non-existent in spinal cord-injured males who do have coitus, although this need not be distressing if they are otherwise able to satisfy their mates.[9]

Women can have coitus successfully, because their sexual organs can function adequately due to reflexes. The menstrual cycle usually continues after cord trauma. Conception is normal, and pregnancy can be full term.[10] Conversely, fertility in men is low following cord trauma. The consensus is that about five per cent to seven per cent

---

[9]F. Friedland, "Rehabilitation in Spinal Cord Injuries," in S. Licht (ed.) *Rehabilitation and Medicine* (Baltimore: Waverley Press, 1968), pp. 517-18.

[10]*Ibid.*

of males can be expected to sire children.[11] Three main causes of sterility are lack of erection or ejaculation, retroejaculation into the bladder and testicular atrophy with the absence of spermatogenesis.[12] Artificial insemination and electrical stimulation are among the processes being investigated by medical science to overcome some of the causes of sterility, but the research is comparatively new, and for some persons moral issues have to be faced.

Sexual attitudes and desires are often affected by spinal cord trauma. Women are relatively less disturbed than men about having sexual relations with their non-disabled spouses. A woman can play a passive physical role in marriage without feelings of shame or inadequacy or loss of femininity. Her sexual organs may lack sensation, but not lack function. If her husband is understanding, she can satisfy his needs and achieve a relatively normal sex life. Injury to the male partner usually involves a reversal of roles in sexual intercourse, in which the wife becomes the active and aggressive partner. This may cause anxiety in the man who feels a loss of masculinity.[13]

As can be seen, adjustment to sexual limitations is an important part of the comprehensive rehabilitation of the disabled person

---

[11]See Doreen K. Weber and Henry C. Wessman, "A review of Sexual Function following Spinal Cord Trauma," *Physical Therapy*, LI:3 (March 1971), 290-94.

[12]H. S. Talbot, "The Sexual Function in Paraplegia," *Journal of Urology*, LXXIII (1955), 91-100.

[13]The implication of role-reversal and the effects of spinal cord trauma on marriage and need satisfaction will be referred to and discussed elsewhere in this study.

to his maximal physical, emotional and spiritual level. In summary, it may be stated that sexual problems of spinal trauma are unique to the person involved and depend considerably upon the level and extent of the lesion.

B. PSYCHOLOGICAL DYNAMICS

The following description and discussion of the psychological aspects of physical traumatization may be taken to apply to severe disability of any origin, as it would be difficult to isolate any unique reactions referring solely to spinal cord injury.

Clinically, the most readily observable and foremost reactions are anxiety and depression. Sometimes these affects are delayed, displaced, or otherwise disguised so that the surface clinical picture suggests their absence. Longer and more careful observation generally reveals their existence and operation. In trying to understand the reasons for a disabled person's anxiety and depression, certain questions present themselves: What does his particular condition mean to him? What are his expectations for treatment, recovery, and future life?

As the most obvious emotional reaction, depression includes the state of dejection, gloomy ruminations, feelings of worthlessness and apprehension, which range from sadness to thoughts of suicide. Where the person indulges in self-blame for the accident or injury causing his injury, his sense of personal loss will be accentuated by a nagging feeling of guilt, especially where the disability is regarded

as punishment for sins.

Coupled with his reaction is anger in the form of resentment and hostility directed not only against oneself and against those professionals who seek to help, e.g., hospital staff and others, but also expressed in the form of protest against or discontent with life in general, fate or God, however conceived. It is acknowledged that in disabled persons the original potential for hostility is aggravated by the many restrictions and frustrations which accompany their predicament. We tend to overlook the primordial status of such destructiveness in human beings, although both the Biblical tradition and the "grand old masters" of European and American depth psychology, Sigmund Freud and Karl Menninger, have been careful to remind us of this.[14]

The reaction patterns of a disabled person are also characterized by an inner struggle between denial and acceptance of his disability. Where a newly disabled person does not appear to be particularly depressed, something inappropriate is almost always taking place, and this ought to be a matter of concern. Not to respond to such a significant event as physical traumatization is denial. Such obvious denial is very rare, except in the case of the very young or retarded persons. What is mostly involved is a negation of functional loss or of the social implications--a denial that the disabled person's life will probably change substantially in important respects. Because denial is the exclusion of an unpleasant factual truth from awareness

---

[14]See Karl Menninger, *The Vital Balance* (New York: Viking, 1963), pp. 114-23.

and also goes counter to reality, it is often the first line of defense a disabled person may take. But there can be negative repercussions, as the person is not making necessary adjustments to his situation. Although denial can be helpful as a temporary solution and as a provisional or transient form of adaptation, it quickly becomes a problem if it persists as an important mechanism, both for the person and those trying to help him.

Denial can assume many forms and expressions, e.g., a haemiplegic patient, after a cerebral accident or "stroke" can have a striking reaction called "anosognosia" in which he completely denies, or is unaware of, his disability. In the case of spinal cord injury denial may show in a clinging to unrealistic hopes of a full "return" or physical restoration. Unless and until the disabled person learns to accept his irreversible limitations realistically, proper and necessary rehabilitative work cannot be done with him. Nor can a sound basis be laid for the courageous planning for the "new life" which Howard Rusk and Eugene Taylor have described as the primary aim towards which all responsible work with the permanently physically disabled is directed.[15]

Since World War II considerable research has been undertaken into the conscious and unconscious factors affecting a person's acceptance of disability,[16] and more recent contributions of Stephen

---

[15]See Howard A. Rusk and Eugene J. Taylor, *Living with a Disability* (Garden City: Blackiston, 1953), and Howard A. Rusk and Eugene J. Taylor, *New Hope for the Handicapped* (New York: Harper & Bros., 1949).

[16]Tamara Dembo, Gloria Ladieu-Leviton, and Beatrice A. Wright,

L. Fink and Nancy K. Cohn have helped to form theoretical models of adjustment to disability. Nancy Cohn suggests five stages of adjustment based upon the thesis that a relationship exists between the patient's attitude towards himself as a disabled person and the quality of his vocational or physical rehabilitation. Her private interviews with orthopedic patients revealed their progressive changes in behavior and attitude, identifiable in five stages:

> 1) Shock: 'This isn't me!' 2) Expectancy of recovery: 'I'm sick, but I'll get well.' 3) Mourning: 'All is lost.' 4) Defense: a. (Healthy)--'I'll go on in spite of it.' b. (Neurotic)--Marked use of defense mechanisms to deny the effects of disability. 5) Adjustment: 'It's different but not "bad."'[17]

Stephen L. Fink[18] has developed four sequential phases through which a disabled person moves in learning to adjust to and cope with the crisis of traumatization. They can be used as a useful framework for examining the specific psychological concerns of paraplegics and quadriplegics and can be amplified by relevant material from Cohn, Dembo, Rusk, Wright and others.

1. The *shock* phase is observable early in the diagnostic and treatment period and commences at the point of the first psychological

---

"Acceptance of Loss--Amputations," in James F. Garrett (ed.) *Psychological Aspects of Physical Disability* (Washington: Department of Health, Education and Welfare, Office of Vocational Rehabilitation, 1953), pp. 80-96.

[17]Nancy K. Cohn, "Understanding the Process of Adjustment to Disability," *Journal of Rehabilitation,* XXVII (November-December 1961), 16.

[18]Stephen L. Fink, "Crisis and Motivation: A Theoretical Model," *Archives of Physical Medicine and Rehabilitation,* XLVIII (November 1967), 592.

awareness of the danger or threat, i.e., of paralysis in the case of spinal cord injury. The disabled person has difficulty in understanding that a change in his physique has occurred and that his body is different. Along with paralysis and a feeling of depersonalization, he experiences emotional numbness. His reactions are inappropriate, and it becomes obvious that he cannot grapple constructively with a plan to cope with the new situation. In the disruption of coordinated thinking, the person feels confused and has trouble in accepting those perceptions which conflict with his more complete body-image. He continues to regard himself as a normal person in pursuit of exactly the same values and goals he followed before the disability.

As a result of his testing of reality and also with the process of time, changes occur in the disabled person, resulting in his gradual recognition of his condition. He realizes that he is dependent on others for bodily care, nourishment and movement. He can no longer walk, or perhaps get into or sit up in bed or use his hands. He also becomes painfully aware that he has no voluntary control over his bladder and bowels and that physically he has regressed to the level of an infant.[19] As the extent of damage to the cord, whether permanent or temporary, is still unknown during this period of shock, in which immediate and intensive medical and nursing care is required, the disabled person needs time to absorb the alterations in his bodily function and to integrate them into the new self-concept which he must

---

[19]Mueller, p. 151.

develop.[20] This fact adds inevitably to the intense feelings of anxiety and helplessness experienced by the patient in the acute stage.

Where the disabled person remains fixed in the symptomatology of the initial shock phase, his persistent denial is an unrealistic attempt to preserve his pre-morbid status and to maintain his pre-injury value system. Obvious denial exists when the person explains that forgetting his disability is the best way to cope with it, and to reduce the number of problems he will have. It may provide him with a much-needed psychological moratorium of emotional relief,[21] which will prevent the onslaught of reality from destroying his value system and from involving the unity of his personality in total chaos. The denial reaction will be shown in "as if" behavior, in his acting "as if" he had not suffered injury.

Denial may also be prompted by the person's need to cope with dependency which he considers unacceptable. His sense of inferiority in being compelled to slow down, as it were, before the idol of physical normalcy, is only intensified and augmented when external assistance is offered. In the face of this, the disabled person uses every psychological and physical means available in trying to ensure his autonomy and independence. Acceptance of any help would be a frank admission of his disability. In effect, he is giving the message:

---

[20] H. R. Black, "Psychoanalysis and Blindness," *Psychoanalytic Quarterly*, XXVI (1957), 1-23.

[21] Dembo, Ladieu-Leviton, and Wright, p. 8.

"Don't help me, because a non-injured person wouldn't need help in this situation."[22]

2. In the second phase, i.e. *defensive retreat*, the disabled person reassures himself that either he is the same old self and nothing is really different, or that the change is merely temporary and he will recover everything that has been lost.[23] Here a defense is activated against the apparently overwhelming implications of the disability. The denial is reinforced and the disabled person's defenses are strengthened by two physical factors.

First, neither the paraplegic nor the quadriplegic actually loses his limbs when he loses the use of them. In contrast to the amputee, who has phantom sensations in his limbs, and can visually correct his mental self-image and so adjust to the loss of function, the quadriplegic or paraplegic sees his limbs. He gets the impression not only that they are visually present, but that he can move them. Thus he is prevented temporarily from entering into the process of mourning and grief over the loss of his limbs.[24]

Secondly, the disabled person usually does make some significant improvement physically. Although the recovery may be limited to sitting in an upright position or transferring to a wheelchair, each progressive step is interpreted as a sign that everything is returning to its former condition and that full recovery is only a matter of

---

[22] *Ibid.*, p. 83.

[23] *Ibid.*, p. 59.

[24] Mueller, p. 152.

time. Here, full recovery becomes idolized and all the person's strivings and energies are incorporated into and directed towards this one, central goal. Cohn has termed this phase a "preparation syndrome" on the assumption that a normal body is implicit in any discussion of future plans.[25] During this state the person will usually openly or tacitly deny any presentation of facts, for reality becomes an intolerable threat.

Like most organisms, the spinal cord injured person reacts to threatening situations either through "fight" or "flight." He will frequently express his defensive retreat in anger, but even this normal reaction will sometimes confront him with his physical limitations. He finds that he cannot throw something, stamp his foot or even walk out. His hostility will be heightened by the frustration at not being able to do previously familiar things and may result in periodic eruption of pent-up angry feelings.

In place of, or concurrent with, the "fight" reaction, the "flight" reaction may occur, involving the type of autistic or wishful thinking characterized by euphoria. In the form of religious ideation, the person may express interest in faith healing or ardently insist that a firm faith in God will ensure full recovery. The underlying and sometimes conscious feeling is "When my body is all right, my world will be all right." In his avoidance of reality-type thinking, the person may appear cheerful and relatively unconcerned about his physical status. This unrealistic condition of contentment may provide

---

[25]Cohn, p. 17.

a welcome respite to the person and those living with or caring for him, but the euphoria will vanish when he eventually faces reality. It is when anticipated physical changes fail to occur and when life does not return to its former state that the person starts to move out of defensive retreat into the third stage.

3. In the *acknowledgment* phase, the person's encounter with the reality of his situation precipitates a renewed period of acute strain and distress. It becomes obvious to him that he is no longer the same as previously. He is different. His feeling of loss is intensified through the personal and social values now denied to him, and so his concentration is upon these lost values. He begins to imagine that his present state is not as good as the way he was before and his self-image becomes depreciated. Valuable goals seem unattainable and his motivation for striving reaches a low ebb. The feelings of deep despair which are engendered are similar to those which William F. Lynch suggests are the bases of hopelessness. These include (a) a feeling of overwhelming, "too-muchness," that life symbolized by the disability is too big and problematic to cope with; (b) a sense of "the impossible," in that whatever the person attempts leads to failure and defeat; it becomes a "no-exit" existence; and (c) a feeling of sheer apathy or futility, in which the person has no stimulation or incentive, no goal, no real reason for continuing to live. Life here is seen as a type of death. At this stage, the person is very prone to suicidal thoughts.[26]

---

[26]William F. Lynch, *Images of Hope* (Baltimore: Helicon Press, 1965), p. 48.

The mourning and grief which a disabled person experiences as he becomes aware of his loss is not negative, but rather healthy and is a favorable prognostic sign. It indicates that the person is recognizing the reality of the condition. The denial has been removed and he has entered a period in which the comparing of his present state to his former one is necessary before he can shift to perceiving himself as a person with valuable assets which still remain. The grief and related mourning behavior as an early reaction to physical traumatization is a crucial phenomenon in any kind of severe disability. Time is needed to get over this kind of loss. To a great extent, time is the healer, a process which Sigmund Freud has described brilliantly in his definition of the "work of mourning."[27] This is especially the case in the fitting of prosthetic or rehabilitative devices. A premature introduction of these or other technics may cause an unfortunate and premature intrusion into the usual vicissitudes of the grieving process. When this happens, the disabled person is not being allowed to get a feeling of himself in new terms and at his own pace. Those assisting in the rehabilitative process may be missing the cue: "I'm overwhelmed; give me a chance to grab hold of myself before you ask so much of me."

Part of the mourning process may include a depressive reaction which is normal and will tend to subside within two to four months with the usual emotional and medical support afforded the person.

---

[27]Sigmund Freud, "Mourning and Melancholia," in his *The Complete Works* (London: Hogarth Press, 1957), XIV, 243-58.

Protracted depression, however, may become pathological and necessitate special care. In this particular phase, the disabled person begins to encounter and cope with specific realities, notably loss of bowel and bladder control, which naturally produce feelings of inadequacy and inferiority. Change in sexual functioning involves facing an identity crisis concerning the person's sexuality. Statistics show that although both sexes are affected, men find it more difficult than women to enter into or resume marriage following spinal cord injury.[28]

An important question which confronts the person with disability in this stage is the problem of dependence versus autonomy. This will be illustrated and discussed in greater detail in the next chapter.

4. When a person has acknowledged the reality of his disability, change is possible and he can enter the fourth and final stage of *adaptation* or *adjustment*. Having plumbed the depths of hopelessness and having come through these to the realization that life still continues and certain things can be done, he begins to visualize goals that can be reached despite his being disabled. In this phase the person with disability develops a modified self-image, a renewed sense of self-worth and a change of values. He is at last able to admit to himself: "Maybe I am not, nor ever will be, quite the same person as I was before, but basically I am still me, and there are ways in which I can be of value to the world around me."[29] Here the

---

[28]Weber and Wessman, p. 291.

[29]Fink, p. 595.

disabled's physical and psychological make-up "grow together." His outlook ceases to be focused on the past, and, assessing his crisis positively, he begins to understand life and its values more deeply and becomes better prepared to meet possible future crises.[30]

---

[30]The psycho-social aspects of spinal cord injury viz. social isolation, decline in social competence, loss or critical modification of social roles, chronic dependency, loss of feelings of self-worth, and loss of morale etc., will be illustrated in extracts from the Interview Questionnaire (see Chapter IV) and from the Person-World Reviews (see Chapter V).

CHAPTER IV

THE *SITZ IM LEBEN* OF THE PERSON WITH SPINAL CORD INJURY

A. INTRODUCTION

For the purposes of this study, interviews of approximately two hours long were conducted with each of the twelve interviewees on the basis of two main divisions of enquiry, viz. ten categories dealing with inner (intra-psychic), covert behavior (Self-Concept/Identity) and eleven categories aimed at obtaining information concerning overt, observable behavior (Life-Styles). In using these twenty-one emphases this type of investigative approach sought to probe the factors of change and ways of adapting to disability through the various *Weltmoden* of persons with spinal cord injury. The interviews were audio-taped and transcribed and descriptive extracts are now included in the results. Positive, negative and neutral or ambivalent responses to the questions in each category are recorded wherever these are identifiable. Male and female single interviewees are recognizable thus: Ms. or Fs. In all other cases M or F denotes married status.

B. SELF-CONCEPT (IDENTITY) CATEGORIES OF SPINAL CORD INJURY

In this first segment of the two-part interview, the enquiries were designed to elicit information illustrating perceived changes in inner, covert behavior which the interviewees related to their spinal cord injury. There was a conscious attempt to encourage expression

of feelings, attitudes and thought processes and to stimulate in the interviewees an awareness of a continuum stretching between bi-polar perceptual stances as each shared his or her self-portrait as a spinal cord injury person. The questions were posed in such a manner as to 'compel' the interviewee to choose between the two poles of each continuum, wherever possible.

1. Stable, Intact Identity in Tension with Identity Diffusion

Here the interviewees were invited to give direct feedback concerning their self-definition by asking themselves the question: "Who am I . . . here and now?" The expanded form of the interviewer's question was:

> 'Speaking as a person with an irreversible physical disability, please respond in any way you wish to the question: "Who is . . . . . (Interviewee's name)?"'

Verbatim responses were rated positive (+) if the self-definitions indicated a degree of clarity regarding the ongoing selfhood of the subject, irrespective of the details of the answer. Responses were rated negative (-) if the interviewee talked about who he/she used to be, or if the attempt at self-definition was obviously amorphous.

> (+) I'm Sue Brown who happens to be a quadriplegic. . . . not just another 'quad in a wheelchair'--some 'outcast of society' who has something wrong with her. . . . First and foremost I'm a person with a disability . . . I dislike being stereotyped as a disabled person. I don't want sympathy . . . I expect to be treated just as I am . . . no special favors. (Fs)
>
> I have a strong feeling about being seen as a person . . . seeing myself as a person . . . trying to be a person that's on my way somewhere. The essence of that is change--one of growth--which hurts sometimes. The disability has been a

revolving point of my life . . . I use it in a lot of ways to be the person I am . . . I don't know who I would have been, but I know what affect it has had on my life. . . . I'm much more sensitive to others. . . . (Ms)

Any difference in me is purely physical . . . the idea that people think quads are courageous or 'wonder people' bothers me. . . . I need to have faith in myself and I do believe in myself and in my abilities. . . . I find maturing is a painful process, but I've grown up so quickly and learned to deal with reality. . . . (Ms)

I need to feel equal with others . . . not inferior. Because I can't walk, that doesn't mean I can't think, have opinions . . . and I *do* have opinions . . . they matter to me and I have to express them. . . . (Ms)

Although I'm a husband, father and have been a banker . . . I've never felt tied to these roles. . . . I've never worried about who I am. I've always been happy with who I am. Since my accident I'm not a different person . . . I'm still me. . . . I think it's important to be myself. . . . I'd fall flat on my face if I tried to be someone else. . . . (M)

(-) I'm not the same as I was before. People don't accept me the same. I don't accept myself the same. Everything's changed for me . . . relationships with people . . . things I want to do and be . . . (F)

Right now I feel as though I'm nothing . . . a failure . . . in limbo . . . I thought I knew before the accident. . . . To begin with, I felt on the scrap heap of humanity . . . I can't really hazard a guess; I seem just to exist . . . sometimes I feel it would be better to finish it off. . . (When asked to amplify the last statement:) . . . I say that when I'm really low, but I don't really mean it. I suppose it's because I feel so lonely and self-pitying . . . (Ms)

Often I'm groping for my identity. . . . I feel 'lost,' insecure, scared . . . fantasizing the way things might be and remembering how they were . . . (M)

I'm a person first . . . the disability comes second. I want to stay with the 'normals' . . . I find it very depressing to mix with other disabled people . . . that's why I haven't joined any of their clubs. . . . (F)

I often feel as though I'm a member of a minority group when people stare at me. . . . I can't help thinking they regard me as mentally retarded as well. When we go shopping or to a restaurant the attendants or waiters always ask Bill, 'What will the lady want?' . . . they never ask me directly!' (F)

2. Anxiety in Tension with Relaxation

This area of enquiry focused on the question:

'Would you describe yourself as more relaxed since your acceptance of your injury or are you more anxious?'

Positive replies indicated lessening of previous anxiety; negative replies denoted intensification.

(+) To begin with, I thought others wouldn't accept me as I was . . . things were so different and yet I knew I was still 'me.' Before my accident I was always a 'goer' and a 'doer.' I was scared people would regard me as a 'freak.' It took me a while to realize they really wanted me to be with them . . . to include me . . . that's been wonderful. . . . (F)

Once I made up my mind to accept my disability and get on with the business of living, I got rid of a huge load of tension. There's absolutely no comparison now with what I felt immediately after my accident. . . . (Ms)

I used to demand immediate attention--then and there. I didn't take into consideration that my wife had other duties . . . I was expecting priority attention . . . I had to learn to be patient and to say 'I'm sorry.' That was difficult for me. . . . Now I feel much more at ease and we're getting on much better as a family. . . . (M)

(-) Every now and then I'm aware of a lot of inner conflict . . . hurt . . . with my accident I had to grow up quickly . . . sooner than I'd expected . . . perhaps that's not bad . . . but I seem to have lost so much of my youth. . . . (Ms)

My greatest battle was with depression after the trauma . . . I was always up-tight and felt churned up inside . . . especially when my parents started making plans for me . . . I felt I needed time to think about things. . . . (Fs)

> I was pretty happy-go-lucky before . . . life went along smoothly. . . . Now I often get very anxious . . . It's hard to be relaxed when the future's so indefinite. . . . What can I do for a living? . . . Who's going to look after me? . . . When I go down to the pub with the 'boys' and joke over a few beers I can forget about it . . . as soon as I talk about the future I get all tense. . . . (Ms)

> I think I'm more anxious . . . especially about when I get older. I can't stand the thought of ending up in a convalescent home . . . I wonder who'll care for me then . . . ? I have to keep on reminding myself to live one day at a time. . . . (Ms)

3. Mistrust in Tension with Trustfulness

This category of enquiry attempted to discover if the interviewees had tended to adopt a more critical and skeptical attitude towards others since their disability.

> 'Do you consider you are more wary of people in general since your injury or have you become more trustful?'

In most cases a healthy tension was maintained between trustfulness and skepticism. Negative ratings were given to those who reported an increase in mistrust.

(+) Before I was injured I was a 'loner' . . . I didn't reach out to anyone . . . felt I could do everything on my own without help from others. Now I realize you just can't live that way. While I was in the hospital and since I've been out, I've felt so much love and support from many people including strangers . . . I've learned to give something of myself besides receiving. . . . (Ms)

> It's taken me a long time to regain confidence in myself. I think I was pretty naïve about people before . . . didn't realize they could be so insensitive 'til now . . . but I must admit there are some exceptions . . . it's wonderful to meet people like that who care . . . it restores your faith in human nature. . . . (Fs)

(-) Right now I'm doubtful about almost everything--including my faith. I suppose I'll trust again, but it'll take some time --perhaps a long time and a lot will depend on what happens

from now on. . . . On the whole I think I've grown more skeptical about life . . . at least I'm being more realistic than before. I don't kid myself that disabled people are the most popular in society. . . . (Ms)

I'm cautious with people I don't know because I've had some unfortunate experiences. It sounds awful to say this, but I'm sometimes suspicious of their motives when they first approach me. I hate sympathy and any hint of pity or condescension. (M)

People have different reactions to a 'wheelchair' person . . . kids are the greatest . . . they have no qualms about asking: 'How come you're sitting down--how come you can't walk? . . . I wish the adults wouldn't wear masks and play games . . . they want to know but won't ask . . . they beat about the bush and go for the safe subjects, hoping they'll find out somehow. They're embarrassed and uncertain . . . my 'friends' have finally gotten around to ask: 'How do you feel today?' . . . They aren't really asking how I feel deep down inside. . . .(F)

I find myself hanging back increasingly from involving myself with people . . . maybe I'm scared of being hurt . . . rejected . . . because I'm different from the 'normal' . . . I feel I've got enough to cope with as it is. . . . (Ms)

4. Depression in Tension with Elation

This identity-related area centered on the question:

'Would you describe yourself as being more depressed since your injury or would you say you were more elated . . . happier?'

Responses were classed as positive if they were elation or celebration-oriented; negative if they were depression or grief-oriented.

(+) I feel great now that I've decided to go to school and train myself for a job that will suit me . . . it's given me hope and something to work for. . . . My girl friend has given me a great deal of encouragement . . . she believes in me and tells me I'm going to make it. . . . (Fs)

Before I left home and took my own apartment I felt trapped. My parents waited on me hand and foot and wouldn't let me do anything for myself. It was getting me down. I'm so glad I plucked up enough courage to leave . . . they didn't like it, but that's their problem. . . . I have to live my own life.

I chose my own attendant and he's great. . . . I feel free to organize things the way I want them. . . . (Ms)

What really got me down was my accident on top of losing a second baby only a year before . . . then all the decubiti and urinary tract infections . . . I didn't think I could take much more. If it hadn't been for Bill's love . . . he's just been marvelous. . . . (F)

I've never been to the point where I consciously wanted to give my life up . . . but I've felt it would have been better had I died in the accident at that time rather than continue as I am now. I suffered tremendous depression from the trauma that I wasn't able to cope with . . . going home at weekends was almost more than I could bear . . . I could never have anticipated the intensity. What finally pulled me out was my wife's challenge: 'Are you going to let the wheelchair rule you or are you going to rule it . . . ?' I realized then that I had a responsibility to my wife and children. That was the turning point. I began to get enthusiastic about living from then on. (M)

(-) On the whole I feel pretty down to things, at times more so than before my accident. There was an acute sense of loss at first . . . something that never really goes away, no matter how much you try to look on the bright side. . . . (Ms)

Basically, I'm a happy-go-lucky person on the outside to everyone . . . but whenever I feel depressed I can't bear to show it to anyone except my husband . . . he understands how I feel. . . . (F)

I really make a tremendous effort to be gay and act as though everything's okay, but it doesn't work . . . anxiety about money, job and especially the future eats away at me inside all the time. . . . I feel as though I am grieving about something . . . say marriage . . . that I feel can never happen now . . . I despair about ever being able to get on top of things. . . . (Ms)

5. Desire for Distance in Tension with Desire for Closeness

This area of investigation opened with this question:

'As a result of your disability do you feel you wish to be more removed from people than previously or do you wish you were closer to others than before?'

Many of the interviewees' replies included the sharing of background information concerning incidents of actual or supposed estrangement, alienation or ostracism, the history of being a "wallflower" or a "lone-ranger" or being a "person who's always felt close to people."

Positive ratings were given to those replies which seemed to indicate that the interviewees had sought more distance from others since their disability. Where the interviewees expressed a desire for more closeness the replies were classed as negative.

(+) After my injury my mother over-reacted and became excessively protective. It took me a long time to realize what was going on and to pluck up the courage to say: 'Hey Mum, just leave me alone, okay?' Now that I'm away from home and have my own pad with my own attendant I feel I'm my own independent self. But I know I still have the love and support of my parents.(Fs)

You could say I've never been very close to people. I valued my independence so much . . . That comes from having grown up in a small community with only a few special friends . . . I've always been very self-sufficient and believed I could make my own way in life . . . It's nice to see people occasionally. I know they care, but I like to be on my own most times. . . . I've always got a lot to do and think about. . . . (Ms)

(-) It gets awfully lonely at times--especially when Bill (my attendant) is away. I often wonder what it would be like to be married . . . my chances are pretty slim that way . . . I believe I want to feel that I belong to someone special . . . but I'm scared of getting too close and then hurt if they leave. . . . (Ms)

I often feel lost and sort of abandoned. I want to be loved and told that I'm needed and wanted . . . to have someone around to talk to who will care about what happens to me . . . accept me and tell me everything's okay. . . . (Ms)

I really want the satisfaction of an on-going deep-flowing relationship. Marriage is a viable possibility, and I realize there must be mutual commitments to make it work. . . . Jo and I lived together for a month . . . then we decided to go on separate vacations and then see how we felt. It was very constructive. . . we still haven't decided what the future holds. . . . (Ms)

6. Freedom in Tension with Bondage

The question addressed to the interviewees in this category was:

> 'Are there any ways in which you see yourself as more free right now than before your accident or do you see yourself as more bound (restricted)?'

Replies were noted as positive where the interviewees' feelings, perceptions and attitudes suggested more freedom in the disabled state than in the non-disabled state. Correspondingly, replies were noted as negative where feelings etc. indicated an increased restriction in the disabled as over against the non-disabled state.

(+) In many ways I feel my personality has changed--especially my attitudes. I get angrier--more direct. When I disagree, I now express it whereas I used to say nothing. I find I'm more frank and honest . . . I don't assume a role merely to please people. . . . (Fs)

I feel freer to explore other possibilities in life--even if narrower. I feel more responsible for myself . . . to make my own way. I'm aware of the difficulties, but I'm prepared to meet those. Obviously, I'm more restricted physically, but I have a good mind and I'm determined to use it. . . . (Ms)

I've got a lot more free time to read and think . . . to do things I wasn't able to do before--I was too preoccupied making money then. When I was young, my parents didn't approve of my 'loafing' around, reading . . . I can do what *I* want to do now. . . . It feels good. . . . (Ms)

(-) I feel a lot more responsibility to my wife and family. I feel they have an extra burden . . . I can't always help . . . that makes me very depressed. . . . (M)

I'm very much confined to home . . . feel cut off . . . can't do what I used to do . . . it gets me down sometimes . . . the four walls start to close in . . . (F)

My responsibility towards the wife and kids frightens me sometimes. I can't plan much for the future . . . I don't seem to have too many options right now. . . . (M)

> I feel pretty much trapped in my condition . . . don't feel it's really fair to my husband . . . perhaps it would be better if he left me and we got a divorce. It doesn't seem as though we've got much of a future as a couple . . . I'm a burden and he'd be freer without me. . . . (F)

7. Self-Responsible Attitude in Tension with a Blaming Attitude

This area concerned the interviewee's acceptance of his/her responsibility in the disabled state. The question posed was:

> 'Who, if anyone, is responsible for where you find yourself right now?'

A positive rating was assigned to responses where interviewees articulated self-responsible attitudes. Responses were classed as negative where the interviewees imputed blame applied to God, fate, self, etc. Although the interviewer avoided the use of "blame" carefully, at least half of those interviewed referred to it directly.

(+) I don't think I wanted to face up to things and deal with them myself . . . it was much easier to hand over the problems to someone to solve for me, especially when they were sympathetic. It took me a while to realize I needed to be in charge of my own life . . . and not to blame others if things went wrong. (M)

It would be a lot simpler to think that my accident was a punishment for things I'd done wrong or for where I'd failed in my life . . . but I don't really believe God is like that. It's my life and I need to accept the consequences of my own actions and do something myself to improve my situation. (Fs)

(-) I took a calculated risk when I went surfing . . . I suppose it's the luck of the draw. I was told it could be a dangerous coast . . . I was determined to try out my own strength anyway . . . so I can't blame anyone or anything except myself. It was foolish, but beating myself over the head with what happened won't make me walk again, will it? . . . (Ms)

If there's a God, I can't really believe He'd let this happen. I want proof of His goodness . . . I really feel bitter towards the man who shot me in the back. I know it was an accident . . . he was supposed to be a friend but he never once visited

me in the hospital . . . perhaps he couldn't face it . . . I suppose I resented the fact that he could still walk and do everything he wanted . . . I can't see any good in this whole thing . . . (F)

8. Personal Goals: Change *vis-à-vis* No Change

This category was designed to ascertain the existence or lack of hopes and aspirations in the interviewees following their disability. The question was intended to reveal something of the subject's meanings and values in life and whether the traumatic injury had blocked or facilitated changes in those inner dynamics. Several interviewees asked the interviewer to clarify "personal goals" and were told "whatever this means to you is fine."

'As a person with a permanent disability have you made any changes in your personal goals?'

Positive responses pointed to a definite change. Negative responses indicated that no specific change was articulated.

(+) I must say I get a lot of satisfaction from doing and attempting things that look impossible . . . there's a sense of achievement in that. . . . You can't disable ambition. . . . (Ms)

I didn't have too many goals before the accident. For a while after I wallowed in self-pity and expected everything to come my way . . . Now I feel an urgent need to get back to school and train for something . . . cosmetology . . . bookkeeping . . . to get some financial independence and security in case anything should happen to Bill and I was left alone with Kay. (F)

I'm much more aware than before of life-choices . . . aware of others . . . I want to care about them . . . I want to meet life head-on and discover new possibilities . . . (Ms)

Since my accident, I've learned that I have to do things for me and to think of my own needs and outlets instead of trying to please everyone else . . . I was driving myself into the ground and I didn't realize it wasn't making any sense until this happened. . . . I see things a lot differently now. (Ms)

I always used to play things the safe way . . . didn't have too much ambition. . . . I can't go on that way now . . . things just don't fall into your lap . . . you have to make some effort yourself . . . even take a few risks and be disappointed sometimes . . . That's been a big step for me. . . . (Fs)

(-) Many people have asked me that . . . I suppose I shoved it to the back of my mind. You could say I was 'escaping reality' and I'd have to admit that. . . . I've never made any definite plans for my life . . . that's where I've drifted along, hoping for the best. . . . (M)

My parents made it too easy for me and I've never developed any incentives of my own. . . . that must sound terrible . . . (laughs). If I set my plans for myself I'd have to live up to my own and others' expectations . . . I'd be scared of failing . . . and so I don't try. If it's anyone's fault, it's mine . . . But I don't let myself be too bothered about it. I figure someone will always take care of me . . . (Ms)

9. Growth Motivation: The Push of Pain in Tension with the Pull of Growth

The following question was addressed to interviewees in order to explore the dynamics of spinal cord injury in terms of the impetus for their continuing to desire change:

'At this moment, what is the driving force behind your urge for your own self-development? Does it come more from a desire to escape from a painful situation or do you strive to fulfill the dream of the type of person you wish to become, whose image you carry inside you?'

Positive rating was credited to responses where interviewees reported a sense of being drawn as their growth dynamics. Negative rating was given in cases where the pain dynamic was cited as motivation.

(+) I feel this is a very important stage in my life--a dynamic period. I'm en route to somewhere else . . . that's not always clear, but I'm sure I'll find out . . . (Ms)

I've always wanted to be a lawyer . . . to plead a case before a jury in court. I enjoyed debating at school . . . I dream of teaching law one day. I'm determined to succeed . . . that's

what keeps me going. . . . (Fs)

To begin with, I could easily have thrown in the sponge and said: 'This is it' to my life . . . I realize now that would have been a cowardly and childish way out. . . I want to make something constructive out of this disability and do something worthwhile with my life. . . . (M)

My accident's been no picnic . . . but it's made me look for some meaning in my life. . . . I think that's Viktor Frankl's phrase . . . I felt before that I was just drifting . . . mostly nowhere . . . now I want to take some real responsibility for what happens to me. (Ms)

(-) I feel very unsettled and mixed-up at times in my feelings . . . trying to be independent . . . but yet feeling so dependent on others . . . I wish I could feel this was just a temporary phase . . . (F)

Most of the time I feel very much in limbo . . . undecided about my future . . . I know I need to get 'off the dime' but I'm not always sure how to go about it . . . I feel I change my mind constantly. (Ms)

10. Cultivation of Inner Resources in Tension with Total Reliance on External Resources

The final question in this first section of the two-part interview was introduced to highlight the issue of autonomy as opposed to dependence: in other words, was the experience of spinal cord injury facilitating more change in the direction of self-actualization or in the direction of leaning on others?

'Where do you seem to be concentrating your energies nowadays--in building your own inner resources increasingly or in looking for help beyond yourself?'

A response was classed as positive where the interviewee described increasing reliance on his/her own developing strengths. A negative response denoted that the interviewee was primarily (if not entirely) borrowing strength and/or advice from others.

(+) I found I was getting too dependent on my friends at the hospital--waiting and listening for them to tell me what to do and where to go next . . . I used to go all to pieces if they weren't there when I needed them . . . Then Tina challenged me to be my own person and get back into the community . . . do something for myself and others . . . I feel a lot stronger in myself for having done that. (Fs)

It seems funny to say 'I have to stand on my own two feet'--when that's impossible (laughs) . . . but I need to develop my own strengths. I find myself being more critical about other people's advice and waiting for a while to see if that's the best course for me . . . (M)

Increasingly, I've been relying on myself to get things done . . . to make plans and so on . . . I'm an avid reader and pick up a lot of valuable hints from books and articles. Some people regard me as an expert on disability . . . I find I can contribute a lot and not be on the receiving end all the time. . . . (Ms)

(-) I got a lot of help from Jim . . . a counselor . . . it was very important to me during my hospitalization. He encouraged me in my desire to be me . . . but it's an awful struggle and I don't feel I'm making it . . . I still look to the staff of the center for guidance and advice when I need it . . . (F)

I find myself going back to the rehab center a lot to talk with the people there . . . it's like a life-line . . . somehow they're 'my community' . . . I feel safe there . . . I don't think I could survive without that contact . . . perhaps that's not the best in the long-run. . . . (Ms)

C. LIFE-STYLE CATEGORIES OF SPINAL CORD INJURY

In this second segment of the two-part interview the investigation was developed in an effort to obtain information describing perceived changes in overt, observable behavior which the interviewees attributed to their disabled state.

1. Changes in State of Physical Health

The following question was put to the interviewees:

'What do you consider to be the most significant changes in your physical condition since you became a "wheelchair person"?'

Positive ratings were given where the response indicated a desire to give up the "sick role" and to be comfortable with a state of "differentness." Negative ratings were given where this transition did not appear to have been completed successfully.

(+) I'm healthy in mind and body . . . I'm more susceptive to other possible illnesses . . . however I'm aware of this and take precautions to remain healthy. I have to be careful about drinking too much--that really causes problems. (Ms)

Like most paraplegics, I've put on a lot more weight since my accident . . . I find I'm very much stronger in my upper extremities . . . that compensates for other things . . . I'm a pretty good basketball player. (M)

My health is excellent. I don't relate my disability problems to any normal illnesses . . . (Fs)

I feel the healthiest and sometimes the unhealthiest among my associates . . . like anyone else, I may die tomorrow . . . The only unhealthy thing I've done or had is to break my neck! (M)

(-) I have constant pain . . . frequent spasms . . . they're embarrassing and that's why I shy away from the public. (F)

Because of weakness in my hands and fingers and lack of coordination I can't play my guitar any longer . . . and that hurts. It may seem irrational . . . but I can't bear to listen to any recorded guitar music . . . (Ms)

I'm basically an optimistic person . . . used to look forward to every day . . . now I wake frequently in the night and can't sleep . . . I know that I'm going to have a lot of internal pain and that I'm not looking forward to that day . . . That's possibly been the biggest change. . . . (M)

I suppose disability comes down to a matter of life and death . . . pain and agony . . . Whenever my catheter's changed, I get a terrible reaction . . . bad headaches . . . cold sweats . . . My attendant put his hand on my head and told me he loved me . . . It didn't take away the pain, but somehow I gathered a little strength. I felt I could make it and wasn't so lonely . . . (Ms)

2. Changes in Personal and/or Domestic (Household) Maintenance Work

Here information was sought as to whether the interviewee was doing more or less work in this area and was coping or not coping with rehabilitation.

'What changes have there been in the tasks necessary for the care of your own person and your home?'

> I have to make more effort and take longer to do things for myself and around the apartment. I also find myself setting different goals and making new decisions. . . . (Fs)

> As a single man I find it very frustrating being responsible for running a house . . . Financially it's very awkward at times . . . trying to avoid the kind of bind I see young couples in . . . (Ms)

> My greatest struggle has been with enforced inactivity . . . I found that hard to accept at first . . . Before my accident I was like a professional housekeeper . . . After I realized I couldn't do what I did before, I was more relaxed about the home . . . my daughter and husband like it better that way . . . now they can help! (F)

> I suppose my wife and I have had a role change . . . she goes out to work . . . I find myself doing much more around the home than ever before . . . but I enjoy preparing the shopping lists and thinking up menus . . . (M)

> I've got a lot of pride still left . . . I don't want people to regard me as an invalid so I don't have any grab rails in the house . . . I suppose I'm rather ashamed of my weakness . . . I'd rather do things the hard way . . . I don't want any reminders . . . I want to live as normally as I can. . . .(F)

> What has been difficult for me is that we haven't been able financially to remodel the house to make it more functional for me . . . I hate not being able to go out and cut my grass as before . . . my wife has to carry out the trash cans . . . something she never had to do . . . that hurts . . . I'm not able to do any of those chores. (M)

3. Changes in Social or Recreational Activities

The following question was posed to ascertain an increase or decrease in time and energy spent in this area.

'To what extent, if any, have you needed to change your social or recreational life since your injury?'

The intent was also to discover whether the interviewee had undertaken any new interests or was merely vegetating.

> I vegetated quite a bit before I decided to do something about my life. It was a big blow to realize my immobility. I used to be so active and now my hopes were dashed. I was always a 'loner'--didn't like large groups or organized activities . . . Now I've taken up swimming and I've met many new friends who enjoy my company. (Ms)

> I find myself mixing with people much more . . . although I loved dancing I used to be a 'wallflower' . . . Now I feel needed and that I can contribute something. For a while I never wanted to see people dancing again . . . it hurt too much to remember . . . Then a friend suggested I could organize a dance party for our club. I accepted and it was a great success . . . I felt really good about that! (F)

> Nothing much has changed on the whole. I still love playing bridge with our friends . . . We used to travel a lot, but we've stayed nearer home . . . We miss other friends and don't see them so much now . . . (M)

> I think I've developed other interests--school--getting a degree. I'm still very interested in athletics . . . enjoy going to meets . . . also YMCA . . . I'm always concentrating on the present . . . (Ms)

> There's a great need for more recreation and creative social life among quads . . . there's more to the person than just being able to accept a disability . . . In some hospitals it can be sheer boredom during weekends . . . like a prison . . . you need mental stimulation . . . No one wants to be a 'perfect' quad twenty-four hours a day . . . there's far more to life than that. (Fs)

> After my accident it seemed as though we got fewer invitations out . . . some of our friends were embarrassed . . . didn't know what to do or say . . . I felt an object of curiosity . . .

> it was very frustrating. Then we moved to a new neighborhood . . . made new friends who accepted us immediately. Some of the women made a point of wanting me to go with them to evening sewing classes and other outings. (F)

> I'm still pretty much in the same activities . . . except in golf and tennis . . . I'm still a very avid spectator . . . It was really hard not be involved any more in basketball . . . but one day my kids suggested I could be a coach . . . I offered and was accepted . . . that's done wonders for me. (M)

4. Changes in Employment/Vocation Orientation

The question in this area was designed to obtain from the interviewee an indication whether the injury had necessitated a change to a new or different occupation than previously, the retention of the same job or if it had motivated consideration of alternative choices for one's life work.

> 'Has your injury obliged you to consider any other occupation for a living?'

> Before my injury I was an assembly worker and sales clerk. I felt pretty helpless when my husband was laid off work. Part of me wants to have a full-time job as wife and mother . . . but I know this wouldn't satisfy me . . . I like people . . . working with them and helping them, so I'd like most to train as a social worker. (F)

> I was interested in horses before my accident . . . rode and trained and was one of the few women jockeys . . . I know I can't ride again but at least I can still train from a wheelchair. It meant a great deal when my employer kept me on the payroll. (F)

> I find it discouraging to read literature about jobs offered to disabled people . . . so condescending . . . that's not really where I am or want to be . . . It perpetuates dehumanization and works on the false assumption that disabled people need to be taken care of and given a little something to keep their hands busy . . . We're capable of doing many jobs just as well and even better than those who are walking around! I would like to see opportunities for employment equalized! (Ms)

> Not having a job makes me feel rather aimless as a person . . . I'm considering going back to school . . . getting some part-time work 'til I can make a decision . . . I'm still feeling my way . . . looking and hoping . . . (M)

> Of course I no longer am the breadwinner and able to support my family myself . . . I don't like my wife having to work . . . As soon as I've got strength I know I've got to do something different from before . . . It's a problem finding what I'm meant to do and can do in the situation . . . (M)

> Because of my accident I just missed promotion . . . Now we're on a much reduced income . . . I know I couldn't go back to my old job . . . wouldn't have the strength to put in the hours . . . So I'm going to have to look for something else . . . At present I'm doing work at home to keep my mind occupied. . . (M)

5. Changes in Parental (Child-Rearing Related) Activities

Here information was sought as to how the interviewee related to his/her children in their life and development within the family setting.

> 'Has your behavior towards your children changed in any respect since your injury?'

> It hasn't been easy to sort out my role as a father . . . I found myself over-reacting with the younger children who were trying to understand my position . . . I found their concern for me difficult to handle at times . . . Before my accident I was the old harsh disciplinarian . . . now I've developed a new approach in correcting them . . . I'm much more patient . . . talking to them quietly and pointing out the object lessons I want them to learn . . . Things are much more pleasant . . . (M)

> My children have become very important to me . . . I'm so glad I spent so much time with them before the accident . . . sporting . . . outdoors . . . but it saddens me to think they will always know me as being in a wheelchair . . . almost never remember me when I was out of one . . . but they're very perceptive and understanding . . . They've taught me a lot. (M)

> My accident's brought me much closer to my daughter . . . she's so sensitive when the other kids say, 'You've got a cripple for a mother.' Sometimes she pulls a 'sick act' and doesn't want to go to school. I go along with her to class when I can and invite her friends into our home ... it exposes them to disability . . . I've developed a good open relationship with Kay . . . not too protective . . . she's very frank with her questions about my body and I answer her honestly. . . (F)

> I'm much more relaxed with the children . . . spend more time with them . . . share their interests . . . They've been affected a lot by my injury . . . under great emotional strain . . . of course we still have some confrontations . . . the use of physical force as a deterrent is out now . . . I think I'm a better model as a father . . . I find they confide in me more. What has brought us together has been our family band . . . I play the saxophone. (M)

6. Changes in Sexual Behavior

Although this intensely personal and probing question was addressed to a subject late in the second hour's interview, the interviewer felt that a sufficiently deep level of trust had been reached between him and the subject before and during the interview to facilitate frank responses.

> 'What changes in your sexual behavior (and in your relationships with persons of the opposite sex) have occurred as a result of your injury?'

> I have a complete lack of feeling during sex and that was frustrating . . . I told Bill he had only 'half a woman' . . . then he tried to knock it into my thick head that the quality of our marriage was more important to him . . . We've slowly built new ways to express our love which are more satisfying . . . and make us more at ease with each other . . . Despite the usual medical histories I could have gotten pregnant again easily, but I have an RH problem . . . besides I was scared about looking after another child . . . so Bill had a vasectomy. (F)

> About my feelings as a man, I find myself ambivalent between my thoughts and my real motives . . . with the wiping out of the sensory part of the experience. The emphasis is now on

> the depth of the relationship . . . that means everything . . . although the sexual part is still there . . . I often think about previous episodes . . . guess it's a way of imagining I'm still a man . . . but my experiences before the accident were a confusing, conflicting pattern of desire for the pleasure part . . . they were unhappy. Mentally, the desire and stimulation are just as strong . . . (Ms)

> As a single woman I think I'm more concerned about marriage than before . . . It's still not a closed option, but I find a wheelchair a barrier to dating . . . People are more likely to date a guy . . . (Fs)

> I'm glad I'm able to provide my wife with some satisfaction . . . however, it's more difficult now. . . you think of the old story of the wife saying, 'Not tonight honey, I've got a headache . . .' . . . Well, that's the way it's become with me . . . 'Not tonight honey, my pains are really hurting . . .' That's been a problem . . . I don't feel the same sexual demand in myself . . . It seems I need to release mentally but not physically . . . (M)

> I miss very much the sexual feeling . . . orgasm . . . sensuousness . . . but I don't think I'm there now. I still see myself as a male sexual person but I don't feel under compulsion to prove my masculinity or to conquer a female, so to speak . . . I enjoy meeting a pretty, attractive girl . . . I want to be liked and thought of as a man and their favorite person . . . (Ms)

7. Changes in the Marital Relationship

This question was aimed at discovering whether the quality of the relationship had improved or deteriorated, and whether role expectations had changed as a result of the permanent physical disability of one partner.

> 'Have any changes and adjustments been necessary in your marriage?'

> I believe Jane and I played a 'cat and mouse' game about the extent of my disability . . . She knew from the doctors but I was pretending to myself it wasn't as bad as it was. When we finally acknowledged the truth, we could then be open with each other and plan realistically for the future, knowing we

had each other's support. (M)

I felt totally 'wasted' as a woman . . . no longer any use . . . then Bill reassured me 'I'm still here and I'm not going away.' He was very supportive and interested in me for more than just physical reasons . . . he loved me as a person . . . our marriage seems to have grown deeper . . . the companionship I mean. There was never any question of a divorce . . . I suppose I'm lucky there . . . so many other women patients had husbands who deserted them . . . and they were very bitter. (F)

For a while I expected Vi to run and fetch everything for me . . . it was easier that way. She used to get mad at me and say, 'It's not my fault . . .' I know she needed to get some of her frustration out into the open rather than bottle it up . . . Every now and then I say to her: 'Hit me on the head when I get demanding and when I can do things myself. . . .'(M)

My wife expected me in the beginning to be able to do a lot of things together that we hadn't time to do before . . . like going to a restaurant instead of eating at home. . . . I ended up going--not to appease her but to sort of straighten myself out--to accept that it was necessary to consider her feelings and wishes more than I had previously. . . . (M)

I know our roles have changed. I've had to struggle with the popular image of the man or husband being the principal supporter of the family . . . that's no longer so . . . I've had to change direction from the goal I had originally . . . Bet's been very cooperative . . . we've had a rough time economically . . . but it's brought us closer together. . . . (M)

8. Changes in Values and Social Attitudes

This question was designed to probe at intellectual and emotional levels the interviewee's perception of his/her own disability in the light of feelings of loss, disadvantage, need for survival and personal satisfaction and achievement, the realization of remaining assets, etc., and the reevaluation of the meaning of life *vis-à-vis* societal emphasis on perfect physique, productivity, etc.

'Have you observed any changes in your personal values and in social attitudes following your disability?'

It took me a long time to realize before I accepted the limitations caused by my injury that there was just as much value in my being who I am as in achieving some predetermined goal which might not now be possible . . . From then on it seemed as though, with others' encouragement, I could achieve so much more in other ways I never dreamed of. . . . (Ms)

When you're in a wheelchair you get a new and different view on life . . . perhaps you have less illusions . . . I think I've learned a lot from observing others more so than ever before . . . I know I still have a mind which I can train and use. . . . (Fs)

I realized I wasn't regarded as a 'freak' by my friends. I decided I couldn't afford to crawl into my shell . . . I had to be out and doing . . . not just sitting at home feeling sorry for myself . . . (F)

When I saw others were much worse off than I, I knew that I had still a lot left and could take pride in developing my remaining strengths and abilities. . . . (M)

Spinal cord injury has made me much more aware of death . . . Most Americans never face this possibility realistically . . . many dread any injury to the spinal cord as a 'partial death' --our society's so hung up on girls having a perfect figure and guys always having a perfect physique as though those are the most important things in life. . . . (Ms)

Before my accident I was a very physical person . . . very conscious of my body and rather vain. I was on the verge of becoming a compulsive house-cleaner . . . I was house-proud and couldn't stand untidyness . . . I was super-independent--couldn't bear anyone to do anything for me. . . The change hasn't been easy. Now I can relax about my appearance and the state of the house . . . The most important thing is having my husband and daughter happy and contented. . . . (F)

It's so easy when you lose the power of your legs to imagine that you're totally disabled . . . because most other people look at you that way. Somehow you have to look at alternatives to realize that there are lots of undiscovered possibilities in life. . . . (Ms)

9. Changes in Religious Attitudes and Expression

Here information was sought from interviewees as to the place

of religious belief as a help or hindrance in their experience of rehabilitation, and as to the importance or otherwise of faith, hope and love as factors and resources influencing their acceptance of, and resignation or resistance to, their life situation.

'What affects has your injury produced on your religious belief and life?'

(+) I have faith in Jesus Chris and His promises . . . I have the love of my wife and children. My accident has made me reflect on all my imperfections and has given me a desire to help others. . . . (M)

My experience has really confirmed my faith in God's strength. I feel I can talk to Him . . . I'm much more aware of His presence . . . life still goes on . . . I'm grateful He didn't take it away . . . I need His guidance in making my decisions. (Ms)

My prayer life has deepened and I know God listens . . . My faith has helped me to be patient and to have the courage to pick up life and carry on . . . (Fs)

Religion has always been important in my life . . . I continue to long for friendship and fellowship . . . This church has been more supportive than other places . . . but I find getting into groups is not easy. (Ms)

I don't believe my injury is God's will. I do think He has something else for me to do . . . perhaps a lot different from what I had in mind before the accident . . . (M)

(-) I think I'm really an agnostic . . . I can't say whether religion has helped or hindered me in this experience . . . I'm still seeking the truth . . . and I'm in a dilemma about things like sin and punishment . . . (Ms)

I've felt very angry about God . . . if there was a God . . . good, loving and kind . . . why did He allow this thing to happen? . . . It kind of shatters your faith . . . that is what it did to mine . . . and to others I've talked to . . . basically good people . . . depriving them of their future and their family's future. I think they feel very hurt by it . . . very let down . . . I know I do . . . I've rejected God . . . (F)

> I feel the Church doesn't really understand spinal cord injury . . . I rarely go now . . . People are status-conscious, not really interested in 'cripples' like me . . . I'm usually the last to leave the Church . . . have difficulty in receiving communion . . . it takes a lot greater effort to make friends. . . . Pastors need a great deal more knowledge to counsel effectively . . . (Ms)

10. Changes in Utilization of External Resources

This question sought to discover to what degree interviewees were adopting either 'leaning,' dependent behavior characteristics and patterns in their disabled state or taking initiative in seeking to develop new support resources. Positive responses articulated the development and current use of new supports on which the interviewees were relying. Negative responses indicated a withdrawal from previous support resources and the substitution or development of no new resources.

> 'To whom have you looked for encouragement, support and assistance since your injury?'

A secondary question was:

> 'Is this different from before?'

> (+) Since the accident, I've been more aggressive in my relations with others . . . the result has been more feedback and this has been good for me . . . counseling has helped . . . that's been a big change . . . (F)

> To begin with, I didn't realize how dependent I was on my father until the accident. He came to stay with us the first weekend I was out of the hospital . . . and he hogged most of the time so that Vi and I didn't get much opportunity to talk about our future . . . She was very angry about this. . . We'd had some problems about communication before, but this nearly finished our marriage. . . . She felt guilty about resenting my father's interference. Fortunately, we went to a counselor and found out what was going on and how to deal with it . . . I feel I can tell Vi now exactly how I feel. . .

She's been a wonderful support. . . . (M)

You get lots of advice from home--'Someone else went through the same thing'--the more you listen, the less it applies to you . . . You try to be polite and take it in . . . It's a difficult situation . . . It's easy for them to talk . . . they've never been in the same boat . . . Fortunately I have a pastor who understands . . . I can talk to him whenever I want . . . (Ms)

My mother-in-law especially . . . we didn't use to talk . . . Now she's wired up to me . . . She asks, 'How's it going?' She really wants to know exactly how I feel . . . bad as well as good . . . I ask her to do things with me--just listen to me--sometimes I feel I lean on her too much . . . (F)

(-) The family were very upset . . . I know we need a bigger car to get me around but we can't afford one . . . I hate to ask my father or brothers for a loan--although I'm sure they'd give me one . . . I suppose we'll manage . . . (M)

I withdrew from my parents . . . they were so protective . . . They wouldn't let me do anything on my own. I seem to have become a 'loner' . . . I know this isn't good, but I don't know how to get out of it . . . (Ms)

11. Changes in Behavior Orientation--Reality *vis-à-vis* Avoidance

The final question in this second section of the two-part interview was of a "catch-all" nature and called for the expression of a value judgment by the interviewee. Posed as a legitimate life-style concern, it was calculated to obtain information illustrating overt, observable behavior.

'Has your behavior become directed more towards reality or more towards avoidance following your disability?'

Those responding affirmatively regarded themselves as acting in ways which were more realistic during the disability than before its onset. Those responding negatively acknowledged that their actions either expressed an avoidance of reality or, if they purported to be reality-

oriented, were in fact more oriented towards avoidance.

No interviewee reported an absence of change.

(+) When I first heard the medical opinion . . . 'you can't walk . . . what are you going to do?' . . . that hit hard. . . . I realized there were some gains that I'd never capitalized on until then . . . I had untapped mental ability . . . I was more aware of life . . . I suddenly acquired a greater knowledge of myself and of the medical profession . . . I can't remember grieving too long over my loss . . . I was too aware of the need for action . . . I knew I couldn't do certain things again . . . I could take short-cuts . . . simple things like parking a car nearer the store . . . It sharpened my decision-making . . . (Fs)

Things were overwhelmingly more real . . . I had a desire to test realistically my behavior by bouncing it off on others. I could actually live and be myself without any apology . . . not just in the safety of a group, but going out on my own . . . seeing what would happen . . . (Ms)

I'm much more direct in my approach than before . . . I have to be to get anywhere . . . I feel I need to make much more effort to be noticed . . . to be listened to . . . not avoided . . . or taken for granted that I'm totally incapacitated. (F)

I think I'm facing things head-on much more than before and I feel more capable since getting professional help. . . . (M)

(-) I find myself withdrawing from situations . . . it's often too much trouble . . . I get tired of the struggle . . . pushing myself against odds . . . (M)

I get too preoccupied with my own problems . . . I don't allow others to do things for me . . . I feel I'm a burden . . . I don't like fussing or complaining . . . I pretend things are okay when they're not . . . (Ms)

I bury myself in work and planning for the kids . . . and think little about what *I* want to do . . . I know this must change, but I keep putting off decisions . . . it's easier and safer . . . less hassle . . . (F)

I'm determined to fight my disability . . . I still hope for a miracle and cling to the hope that some day there'll be a medical discovery which will give me back the use of my legs . . . It's not an easy life . . . It's got many heartbreaks. (F)

> I don't deal with the real problems until I'm challenged by _____. I just don't allow myself to think too much . . . it's too painful . . . You know, I really didn't see it that way until you asked me that question . . . I'm not really dealing with things . . . I keep on denying they exist . . .(Ms)

D. SUMMARY

An examination of the foregoing data extracted from the interviews reveals that for the spinal cord injury person his self-concept (identity) had undergone trauma and his life-style had changed considerably since the onset of disability. A substantial reorientation in each category was involved.

In self-concept (identity) categories the results revealed more significantly feelings and perceptions of the self as being in transition; a re-focusing and re-thinking of personal goals; initial identity diffusion progressing to more stable identity as the transition from "sick" to "different" was successfully accomplished; increased initial anxiety and depression, especially in males; the pull of growth as the primary motive for working at the development of inter-personal relationships.

In life-style categories the results revealed more significantly a tendency to increase household and personal maintenance tasks; more vocationally related behavior changes; heightened leaning on others for support; increase in religious activities, though not necessarily in a formal way; the performance of more reality-oriented (as opposed to avoidance-oriented) acts as a function within disability.

No conscious differentiation was made between men and women

in this study. While several of the interviewees felt, thought and behaved similarly, thus indicating overall sample tendencies, nevertheless differences were discernible. These were significant because the findings suggest that these differences correlate with their gender. It was not the aim of this project to speculate as to whether men or women interviewees tended to respond in contrasting ways to the same stimuli, although such inferences would provide interesting causative hypotheses to be tested in another investigative study.

In general, males responded with less identity-diffusion than females. The reason for this may be that for some women the onset of spinal cord injury was the first time they had confronted the issue of self-concept (identity), values, needs and goals. Prior to that time most of them had progressed in a relatively protected way from the role of daughter to that of wife.

Although the sample as a whole exhibited depression, males tended to be more anxious, especially in relating to others, and concerning job possibilities, the future and approaching old age. Women appeared to have many more on-going interpersonal relationships on which to rely, whereas men had no ready-made network of support available. While the analysis disclosed no significant contrast in male-female utilization of external resources, an impression was created from the results that women subjects found it easier to adopt increased "leaning behavior." Men tended to be more compulsive about preserving their pre-morbid male image, especially that of husband and father.

Concerning changes in sexual behavior, males were generally

more anxious concerning this life-style category, whereas women were much more relaxed. One single woman reported that she felt that opportunities for dating had been reduced noticeably as a result of her injury.

In the matter of household maintenance tasks, men reported substantial role reversals in marriage where the wife became, in some cases of necessity, the principal breadwinner. Not all were relaxed about this, especially when heavier work became the responsibility of the wife. Single men tended to feel the burden of extra responsibilities in setting up an independent household. Males tended to reveal more deterioration in physical health, more concern about body-image and advancing age and more perception of themselves in bondage than females.

Both sexes admitted to being forced to mature at an earlier age through the confrontation of vital issues in their lives. On the whole, men tended to resist offers of help in trying to preserve their independence. The majority of singles of both sexes realized the necessity for trying to create a separate household to insure positive dependence. Most of the interviewees saw the changes in parental (child-rearing related) activities as positive in that more time was often spent with children than before, and the disability itself acted as a change-agent to enhance relationships within the family. Disability was seen to cause persons to re-evaluate and re-focus their personal goals as identity became diffused and re-defined.

Spinal cord injury invariably made definite vocationally-

related behavioral changes as a functional response to disability. This took a variety of forms, e.g., enrollment in school for further education or re-training for another job and applied equally to men and women.

Men tended to change sexual and household related behaviors more radically than women and disability often produced a low level of trust in men especially concerning relationships with strangers. This is largely an outcome of societal and cultural attitudes, a fear of not being able to achieve satisfying relatedness because of the disability.

Most interviewees reported that their behavior was more reality-oriented than avoidance-oriented since the onset of the disability. This was particularly the case where persons had sought counseling which was both supportive and confrontational. As a result, there had been a movement towards a self-responsible attitude as opposed to a blaming attitude and a desire for mature self-actualization.

PART III

CHAPTER V

THE EXPERIENCE OF SPINAL CORD INJURY FROM THE ONTO-THEOLOGICAL PERSPECTIVE

The preceding chapter provided a descriptive presentation in fine detail of cumulative data obtained from the researcher's interviews with twelve persons. Although they did not constitute an actual group in the sense that they knew each other personally or were hospitalized concurrently, nevertheless the total information gained from separate interviews is illustrative of several aspects of the phenomenon of spinal cord injury. From this and the results of the Self-Insight Questionnaire and supplementary inventories and questionnaires, general conclusions will be drawn and presented at the conclusion of this chapter.

As detailed reporting of the interviews of all twelve persons would be impracticable, two interviews involving one man and one woman have been chosen to illustrate in some depth the ways in which these individuals have coped with their finitude, either positively or negatively. On the basis of their own self-affirmation and their acceptance or rejection of others' affirmation of them in their differentness, indications will be given concerning movement towards maturity or immaturity in their growth and development as persons with permanent physical disability.

A. PRESENTATION OF PERSON-WORLD REVIEWS

1. Len

Len, a 39-year-old married black male paraplegic, was confronted by the threat of non-being in the form of imminent death when he suffered a fracture dislocation of T^9, which subsequently necessitated a laminectomy from T^7 to T^{11}. The accident involved a fall from a three-storied industrial building during construction.

Following the trauma during the acute hospitalization phase, Len, a well-developed, muscular man, experienced existential anxiety as he began to consider his future. This was heightened during the weekends when he visited his wife and children at home prior to his discharge. What intensified this in him was the difficulty he began to have in re-defining his role as a father and husband. Culturally, he had always laid great stress on maintaining a strong male role in and out of the home and this he had assumed without question. He was used to being the breadwinner and felt primarily responsible for the support of the family, taking considerable pride in this. He also made the major decisions on family policy.

After the accident, he found himself suddenly in a position of weakness and dependent upon help from his family which he found hard to accept because of his previous self-sufficient stance. In his struggle with his finitude, Len was experiencing a conflict between being and non-being. His resistance to accepting his disability caused him severe depression and anxiety. To counteract this he

tended in the beginning to deny the existence of any problems and to refuse to discuss them with his wife or anyone else. How could he admit his limitations and still maintain his integrity as the strong husband and father who was in complete control of the situation? If he failed to come up to his expectations in this respect, how could he still be loved and respected? In failing to affirm himself as finite and "different" Len was in danger of developing a type of pathological anxiety in which there was an unrealistic security in his attitude of "I'll fight back; I'll show the world that I'm still a man!" This was a desperate attempt to avoid the anxiety of fate and death. The anxiety expressed itself in his over-reaction with the younger children.

In an attempt to preserve his image at all costs, he became compulsive about insuring the welfare of his family, about exercising strict discipline and in making decisions affecting the entire family. The fact that the insurance company procrastinated in the settlement of his disability claim made it impossible for him financially to remodel his home to meet his needs. He interpreted this as rejection and began to internalize his anger. As a member of a minority group his feeling of rejection became more pronounced as he encountered instances of apparent discrimination; he felt dehumanized and worthless.

Within his life Len was experiencing conflict between the ontological polarities of existence including tension between his essential being and existential estrangement. His wife suggested to him that they could perhaps do things which they had not done before,

e.g., go to a restaurant instead of eating at home. Previously, Len had always resisted this. He knew he could not go back to carpentry; he was intelligent and the opportunity for self-fulfillment in a training for different vocation was now possible. But he would have to be prepared to accept help from others, including his wife, which he resisted. In integrating his secret desires to succeed as a man into his centeredness, in growing beyond feeling helpless like a child in his disability, in reaching out to others, in experiencing his own dignity, and in making free decisions, Len would be able to restore the unity between freedom and destiny in his life. But his initial reaction to these possibilities was depression--not elation.

The basic reason for his negative response was his strict upbringing in a fundamentalist church where one's lot, good or bad, was believed to have been ordained by God. This produced in him a tension between dynamics and form which he projected on to his wife. She had a beautiful singing voice of which he was very proud. Professionally trained, she could have used it in a secular setting, but he insisted that she should give her talent to the church and not let it be "corrupted by the evil world." He expected her to conform to his own rigid code and to sacrifice her own desires. He himself was offered a job which included duties on Saturday. He really wanted this job but refused it because it conflicted with his religious beliefs. In the physical side of marriage he resisted any suggestions of alternative methods which he claimed offended his moral scruples.

Len's rigidity and uncompromising attitude began to produce

disintegration in the family, leading to a hopeless situation. He knew he had to re-orient himself into another job, but he was unskilled for many positions. This intensified his feelings of inadequacy. Non-being confronted him constantly in the form of guilt in not fulfilling his latent potential and in intense insecurity (fate). An impasse was reached.

His wife became frustrated with his apparent indifference to her needs and his domineering manner and authoritarian attitude towards the children. She declared she was "not prepared to continue enduring that treatment" and suggested separation. In view of his fundamentalist religious beliefs, this constituted a threat of non-being to Len. Because of the conflict between dynamics and form, Len felt unable to modify his behavior. Internalizing his anger at perceived rejection, he began to withdraw and to allow the world to revolve around him without any noticeable effort on his part. He used to sit in his wheelchair all day long looking at the front door after his wife and children had gone to work and school and would still be there when they returned home. One day his wife challenged him: "Are you expecting someone or something?" His sullen silences irritated her. She asked "Are you going to let that wheelchair rule you or are you going to rule it?"

The break-through came with a final confrontation with the children who declared that they also wanted to leave home and their father. Len then realized that he had "reached the bottom of the barrel," that he could no longer perpetuate his self-destructive

behavior, and that he needed to change his style of relating and to acknowledge that his wife could not continue to bend to his demands at the expense of her own needs, integrity and self-fulfillment.

He dropped his compulsive efforts to avoid the anxiety of fate and death which were akin to a religion of works-salvation, and began to allow his wife and children to accept him in their activities. The balance between individualization and participation was restored. As he accepted his existential anxiety into his self-affirmation, the symptoms of denial and compulsive behavior disappeared. He encouraged his wife to develop her own independent interests and to share equally with him the responsibility for providing income to support their family through pursuing her profession as a nurse.

For himself, he accepted advice from friends and enrolled in some college courses to train as a social worker. In doing so, he assumed responsibility for his own self-fulfillment. Anxiety concerning his own future and the general financial situation was still present, but it did not dominate his life and cause an escape into forms of pathological anxiety. Instead, he was able to accept this natural anxiety into his life as normal. Non-being in the form of his disability was still present, but did not prevail against being. He courageously accepted his limitations into affirmation of his essential being. He was also able to accept from his wife and children their love of him as a worthful person who did not need to "prove" himself, and he learned to receive their love as a gift.

In making the choice to do something for himself and at the

same time feeling good about it, the estrangement from his essential nature was partly overcome. He was able to affirm the essential unity of individualization and participation in sharing his own life with those of his wife and children at a deeper and more intimate level than ever before. This was an integrative experience. He was now able to assimilate any negative reactions from his wife and children into his centered self without feeling destroyed by guilt or rejection.

The courage to be which Len derived from an awareness of the Power of Being and being grasped by it gave him a new sense of balance between freedom and responsibility and increased enjoyment in sharing himself with others. The new courage taught him patience, gave him hope and produced growth and maturity in place of his previous immature, self-destructive and disintegrative behavior. His prognosis for successful rehabilitation is good. Based on the Self-Insight Questionnaire (see Appendix D, p. 251) and staff evaluation, Len was seen to exhibit some pre-morbid personality traits which were still in existence at the time of the interview, e.g., rigid, demanding, stubborn, impulsive, domineering, rejecting his own limitations, failing to recognize the consequences of his bahavior and not fulfilling his potential.

2. Jan

Jan is a white female paraplegic, aged 29 years, married with one daughter aged 4 years. The threat of non-being in the form of imminent death presented itself to Jan when she became the victim of

a gunshot wound resulting in a lesion at L^2, which later necessitated a laminectomy at T^{12} through L^2.

The injury compounded several pre-morbid experiences of conflict between being and non-being and between essence and existence. Prior to the accident she had been an intensely active ("physical" as she described it) person, keen on outdoors life, camping, hunting, fishing and working with her hands. A considerable amount of this had arisen from her relationship to her parents and sister before her marriage. Her father had wanted a son and had been disappointed when his first child was a girl. Because she felt she could never prove herself to her mother who favored her young sister, she tried to satisfy her father's expectations of her by acting as a tom-boy. He in turn compensated for his disappointment by treating her as a boy, allowing her to wear blue jeans all the time and to work on cars, etc.

Even at that stage there was a real conflict between her essential being and her existential situation. Deep down she longed to be seen as "feminine" as her sister, for whom her mother was always making pretty dresses for parties. When it came to dating, she became anxious, feared intimacy and assumed a false independence by always insisting on paying her own way. Her father began to realize his mistake and tried to encourage her to be more feminine. This caused mixed feelings about herself and she started to play a "hard-to-get" game with any would-be suitor. This was a device to create a safe distance between herself and her father and other men.

But, eventually, she met Bill who was equally keen on outdoors

life and they married. At last she became aware of being grasped by the Power of Being and allowing her potentiality as a woman to come to birth. Through marriage, her previous dependency needs which had precipitated an anxiety of fate were gradually overcome.

The fact that she had an RH blood problem and had a miscarriage before her second child was born precipitated a recurrence of anxiety in Jan about her essential being as a woman. She compensated for this by driving herself compulsively to prove herself equal and acceptable to her husband by accompanying him and his friends on every hunting and fishing expedition, and not merely as a cook. She felt less and less interest in domestic pursuits around the home. Even the birth of their daughter did not change her attitude.

The shooting accident was traumatic for Jan and her resultant immobility made her severely depressed. This was intensified by Bill's becoming unemployed. His presence around the house aggravated her depression and her feelings of failure and inadequacy as a wife and mother. Her previous compulsive behavior found a new outlet in compulsive cleaning which exhausted her physically. She was becoming the victim of pathological anxiety in the form of unrealistic perfection by failing to accept the anxiety of guilt and condemnation into her own self-affirmation. Her preference for men's company in the home stemmed from her feeling of being uncomfortable among other housewives and inferior to them.

Her compulsive activity was also an expression of denial of her finitude experienced through her injury. She found it virtually

impossible to accept that she could no longer do what she did previously. She insisted on appearing and being "normal" and refused to be identified with other "wheelchair" people. Because of her marked physical orientation, Jan also had difficulty in assimilating an altered body-image into her own self-concept. She resented the fact that the man who shot her accidentally never once visited her in the hospital or enquired about her condition. Her feeling of rejection was compounded by the fact that when she first returned home from the hospital her friends regarded her as something of a "curiosity." Invitations to go out fell off and she began to withdraw, internalizing her anger. Things began to improve when Bill and she moved to a new neighborhood and people started to call and befriend her.

Part of her unrealistic perfection had previously taken the form of being falsely "cheerful" to everyone even though she was hurting inside. The only person in whom she had ever confided was Bill. Gradually, other women sought her out and when she felt their genuine concern and support of her, despite her limitations, she began to lower her defenses and reach out. She accepted invitations to shop and join a sewing club and realized that she could develop hitherto untapped abilities which could satisfy her innate desire to be truly feminine. She began to appreciate and enjoy the company of her mother and sister. Her relationship to Bill and her daughter changed and she no longer felt intolerable pressure to prove herself acceptable to them in unrealistic and self-defeating ways. She could relax and affirm herself in the role of a true wife and mother who could be loved just for who

she was.

There was a time when Jan, in fighting her disability emotionally, clung desperately in fantasy to a hope for a miracle medical cure which would restore her mobility. She had no definite religious convictions and harbored resentment towards God for allowing the accident to happen and cut off her youth and activity. Before the injury, she had subscribed to a religion of pleasure and had placed ultimate value in a life which shielded her from all unpleasant experiences. But this also encouraged her to be irresponsible in many areas of her life. She showed little motivation, had difficulty in setting goals for herself and was very dependent on others, especially Bill. This revealed an imbalance between freedom and authority in which she forfeited her freedom through avoidance of her own authority. She could see no inner resources within herself and felt tossed to and fro by external forces. The result was that she was unable to accept responsibility and retreated from making decisions.

She began to view God in terms of demand and interpreted her injury as the result of punishment for sins she had committed. She found no sense or meaning in suffering and no positive potential for growth or learning. She tried to escape from any form of change to avoid anxiety and loneliness and in her dependency on a few others was aware that she was borrowing her selfhood from them. In the rehabilitative center she participated minimally in physical therapy and approached her disability in an attitude of hopelessness and despair with no values or goals to provide her with the challenge to fulfill

her potential and responsibilities.

When Bill and her friends confronted her with her complaining and demanding attitude, her tendency to blame others and her reliance on others to perform tasks she could easily do for herself, she realized that she could no longer live her life in such self-destructive ways.

As she became aware of being grasped by the Power of Being through others' affirmation of her, she had the courage to be. Still holding an agnostic position, she regards herself as a seeker of the truth. She feels she is at a middle stage in her growth towards maturity. Whereas she felt she was vegetating before she decided to exert herself, she now likes to "do something which looks impossible . . . even if it takes longer and more effort . . . I have a sense of achievement."

Her aim is to train for a bookkeeping position to achieve some financial independence, in case of a family emergency. Concerning thoughts on advancing age: "I just live one day at a time and try not to worry." Jan has a real sense of loss, but also of hope. "Others can do it, why can't I?" With considerable support and affirmation from her husband and friends, the prognosis for a successful rehabilitation is favorable.

Based on the Self-Insight Questionnaire (see Appendix D, p. 252) Jan was observed to exhibit several pre-morbid personality characteristics which were still evident at the time of the interview, e.g., being easily upset, impulsive, unpredictable, dependent,

indecisive, rejecting her own limitations. Whereas she rated herself as fulfilling her potential, the staff and her husband indicated otherwise.

B. RESEARCH FINDINGS

1. Results of the Self-Insight Questionnaire[1]

In using an adapted form of Heath's instrument in this study, it has been assumed that behavior is one expression of a person's maturity and indicates the way in which a mature individual relates to his world and responds to his perceptual awareness of it. Within the questionnaire, an attempt has been made to illustrate Tillich's ontological determinants alongside Heath's test of emotional maturity and immaturity.

Mature behavior is classed as that which affirms a person's self as interdependent, being free yet finite, and open to change. Primarily, it can be defined as a dynamic state of being unified in favor of self-integration, self-creativity and self-transcendence. Immature behavior is quite different in that it fails to unify a person's self in the above three dimensions. In the course of the Person-World Reviews and the administration of the Self-Insight Questionnaire to the interviewees, certain observable or revealed behaviors have been shown to be positive (mature) or negative (immature) values of Heath's maturity scale.

---

[1]A copy of the Self-Insight Questionnaire together with two sample score graphs of results can be found in Appendix D, p. 241f.

Tillich's ontological polarities have been matched with the following behavioral expressions of maturity and immaturity:

(a) Individualization and Participation: open-defensive, suspicious -trustful, easy-going-demanding, stubborn-compliant, predictable -unpredictable, aggressive-gentle, domineering-submissive, purposeful-purposeless, self-centered-other person-centered, understanding of others-not understanding of others, cold in personal relationships-warm in personal relationships.

(b) Dynamics and Form: objective-subjective, accepts self-rejects self, self-perspective-self-involvement, rigid-flexible, ordered-disordered, easily upset-unshakable, enthusiastic-unenthusiastic, imaginative-unimaginative, cautious-adventurous, strong convictions-weak convictions, low aspirations-high aspirations, fulfilling his potential-not fulfilling his potential.

(c) Freedom and Destiny: dependent-independent, apathetic-energetic, self-disciplined-impulsive, reflective-unreflective, realistic-unrealistic, decisive-indecisive, anticipates consequences-not anticipates consequences, accepts own limitations-rejects own limitations.

The ratings in the Self-Insight Questionnaire were designed merely to show and describe trends in the perception of the disabled person's mature-immature personality dimensions with the three degrees "mildly," "moderately," and "very" on either side in each pair of traits. No attempt was made to extract results of any statistical

significance.

First, the twelve persons to whom the Self-Insight Questionnaire was administered rated themselves on the basis of their mature or immature personality dimensions.

In terms of maturity, they saw and recorded themselves (the ratios are shown in brackets) as warm in personal relationships (10/12), other person-centered (8/12), energetic (9/12), strong convictions (10/12), high aspirations (9/12), enthusiastic (9/12), purposeful (8/12), and aggressive (7/12).

The highest scores concerning immaturity items were dependence (6/12), not fulfilling potentials (7/12), indecisive (7/12), easily upset (8/12), impulsive (7/12), subjective (4/12), demanding (7/12), and domineering (6/12).

The researcher was tempted to assume that the chosen "friend" would probably tend to be less inclined to evaluate the person negatively, and that his perception might correspond more closely with the person's own self-perception; also that the staff member's evaluation might afford a more reliable correction of the friend's likely bias. However, in some instances, the results, illustrated by the sample graphs in Appendix D, indicated that the friend's perception was not necessarily congruent with the person's own self-rating.

Ratings of the disabled persons by friends or significant others indicated an increase in neutral responses. Maturity dimensions included realistic (6/12), purposeful (7/12), independent (6/12), predictable (7/12), other-person centered (6/12), high aspirations (8/12),

enthusiastic (6/12), energetic (7/12). The highest immaturity dimensions recorded were: cautious (7/12), not anticipating consequences (6/12), subjective (6/12), disordered (6/12), impulsive (7/12), domineering (6/12), rigid (7/12), and aggressive (6/12).

Rating of the disabled by rehabilitation staff members and other professionals disclosed high immaturity scores in the dimensions of stubborn (8/12), demanding (7/12), impulsive (7/12), domineering (6/12), rejecting own limitations (6/12), disordered (7/12), adventurous (7/12), and unreflective (6/12). Maturity was rated on the basis of self-discipline, realism, purposefulness, high aspirations, enthusiasm, openness, and other-person centeredness.

In general the Self-Insight Questionnaire results indicated that the person with spinal cord injury is flexible, open, enthusiastic, has strong convictions, is decisive, understanding of others, warm in personal relationships, independent (in the sense of positive dependence), and fulfills his potentials. These items of emotional maturity can be related to Tillich's unified ontological polarities. For example, the life process of self-creativity is at work in the unity of the dynamics and form polarity and is evident in the behavioral expression of fulfilled potentials and high aspirations. In most of the interviewees a large measure of courage was discernible, even if that meant experiencing failure or disappointment in achieving their goals or otherwise. They were in touch with their weaknesses and so became strong enough to attempt challenges again and again. They also resisted a compulsiveness to meet their own expectations and those

of others as the sole motive behind their decisions to take certain courses of action to prove themselves worthy of affirmation. Self-destructive tendencies were evident in a few cases where the person failed to try, resulting in a reduced sense of self-esteem, or where, through pride or grandiosity expressed in a denial of the reality of his condition, he attempted unrealistic goals. Here a false identification of his self-worth with the functional aspect of his physical being made him vulnerable to the threat of losing his self if he did not measure up to expectations.

The life process of self-integration is at work in the unity of the polarity of individualization and participation, where the maturity dimensions of purposefulness, other-person centeredness and warmth in personal relationships are found. The disabled person has to live in the present but the thrust of his being is also oriented towards the future in the direction of some culmination. There is therefore a desire for meaning and purpose in life and for the establishment of meaningful relationships.

The life process of self-transcendence is revealed in the unity of the polarity of freedom and destiny. This is evident in the behavioral expression of independence (actualized in the person with permanent physical disability as positive dependence), decisiveness, anticipating the consequences of actions and accepting one's own limitations. Self-profanization occurs when a person becomes so dependent on his environment that he becomes identified with it and cannot see beyond his condition of physical disability which he can use as a means

to manipulate others, to avoid dealing with problems, taking risks and making plans and commitments for the future.

Through his acceptance of *agape* love communicated to him by others, the person with permanent physical disability can be comfortable with his finitude and can feel self-esteem with and despite his physical limitations. This enables him to face the present with courage and conviction and to transcend his immediate condition as a person of faith and hope.

From the research it has been confirmed in the writer's mind that there is no such thing as a unique constellation of personality characteristics which can be attributed to the consequence of spinal cord injury. As with all other disability groups, there is no direct relationship between the type of physical condition and personality structure. The absence of such an inherent relationship will not surprise those oriented toward the field of somatopsychology. Here a long-standing important principle has been that somatic abnormality as a physical fact is not linked in a clear-cut, direct way with psychological behavior. Stated more simply: unlike the medical area, where appropriate reference can be made for many purposes to specific diagnostic conditions, in psychology the proper emphasis is on the person rather than on the condition. Therefore, permanent physical injury is only another type of stress situation in which the person involved brings a repertoire of response patterns characteristic of him personally. In this respect, all insights into the bases of human behavior are applicable. The more attuned professional staff and

members of the general public are to a psychological level of functioning, the more capable they are of sensing their own feelings in past stress situations and the more effectively they can help persons with permanent physical disability.

Although reaction to physical disability is idiosyncratic, a particular kind of condition, such as spinal cord damage, restricts certain functions while leaving others untouched. It is feasible to isolate certain functional issues as being fairly specific to the condition and to look for personalized reactions to these common problems. Foremost among these problems are elimination control, decubiti, sexual response, muscular contractures and severe mobility restrictions.

2. Results of the Religious Inventory[2]

This thirty-item instrument was formulated by the researcher and was administered to eight of the interviewees. It was designed to amplify and expand on answers to the questions presented in the Interview Questionnaire concerning changes in religious attitudes and expression under the Life-Style Category L.S. (9).[3] In view of the wide diversity of theological opinions held by the interviewees, it is impossible to draw any specific conclusions on the data obtained using such a limited sample. However, the results indicate certain general beliefs concerning man and God and their relationship and attitudes toward life before and after the onset of spinal cord injury.

---

[2]See Appendix B, p. 233.

[3]See *ante*, p. 182f. and Appendix A, p. 230.

Of the total of eight responses to each statement, the highest neutral scores (ratios recorded in brackets) were in respect of statements 6 (4/8) and 12 (5/8) which seemed to indicate that those persons were surprisingly ambivalent in their attitudes concerning the love of God as a binding force among people and as a change-agent in the world.

The scores in which there was the highest degree of agreement applied to statements 3 (5/8), 4 (5/8), 5 (7/8), 13 (5/8), 15 (7/8), 16 (6/8), 17 (100%), 18 (6/8), 19 (5/8), 22 (100%), 25 (7/8) and 29 (5/8). There was complete unanimity concerning man's basic need to love and be loved (17) and the incompleteness of the interviewee's life up to the time of the interview (22).

The interviewees expressed themselves strongly concerning man's inherent and indestructible goodness (3), man's inhumanity to man as the greatest sin (15), the worthwhileness of one's life in the event of death (18), contentment with the quality of one's life in retrospect (25), and the ultimate control over one's attitude to life residing solely in oneself (29).

There was substantial agreement that love, not wrath, is the essence of God's nature (13), that God loves man just as he is (16), and that God exists (19). The majority agreed that service to God is expressed through helping one's neighbors (5). Several (5/8) noted the importance of spending time in private religious thought and meditation (4). Half of the interviewees indicated that if they had the choice they would live the same life again (21).

The scores in which there was the highest disagreement applied

to statements 2 (6/8), 9 (7/8), 10 (7/8), 14 (6/8), 20 (7/8), 24 (7/8), 28 (6/8), and 30 (7/8).

Most were very reality-oriented about their life situation in the world (2), and disagreed that no one in the world was good, least of all themselves (9). The latter response corresponded with the affirmative response to statement (3) concerning man's basic goodness.

There was strenuous disagreement toward the statements concerning man's sin and worthlessness (10) and his deserving of any punishment from God (14) and the unpardonable nature of his sins (30). The majority resisted the suggestion that the fear of death was an increasing part of their experience (20), that their lives were aimless (23), that their lives had progressed pretty much as planned (24), that their present life-style did not reflect what they had been in the past (26), and that no one cared what befell them (28).

Interesting negative responses were given to statements 7 (religious beliefs really lie behind the whole approach to life), 8 (the knowledge that God loves one like a father loves his children is the most important thing in religion), 11 (that the primary purpose of prayer is to gain relief and protection) and 27 (that persons with spinal cord injury were very religious, more so than most people). The last response may be interpreted as applying to formal religious expression.

In addition to the foregoing, some observations will now be made concerning the place of religious faith in the experience of persons with spinal cord injury in the light of the data obtained

from the inventory and the interview questionnaire (L.S. Category 9).

Religious faith is seen not only as a positive factor but also as a vital intangible element in rehabilitation providing strength to meet crises. In several cases persons did not find any meaning or relevance in their faith until they were confronted with injury and felt inadequate to cope with the trauma. There was no suggestion that persons with spinal cord injury acquired any special kind of faith, although most reported an increase in religious beliefs and practices (mainly informal) since their accidents.

Several indicated that because of personal religious faith they were better able 1) to tolerate pain and frustration and see life as meaningful and purposeful; 2) to evaluate their injury as a loss but not as a negation of their dignity and worth; 3) to be encouraged and motivated towards an optimum measure of independence; 4) to be more cooperative in the rehabilitative process; 5) to maintain constructive and positive attitudes towards recovery; 6) to have hope and the will to survive where the prognosis seemed hopeless; 7) to discover and move towards realization of a higher and nobler self, and 8) to repair damage inflicted by the disability in terms of loss of self-esteem, confidence and acceptance.

In a very few cases religious faith seemed to serve the purpose of denial where the person was blindly optimistic and negated any feeling of loneliness or where his awareness of the severity and seriousness of his injury was blocked. Immaturity was shown in one instance where unrealistic expectations of a miracle cure were held with

resultant hostility towards physicians. It was also evident whenever the martyr's cloak was donned to manipulate and control the household and where hiding behind the disability was used as an excuse to avoid meeting the challenges, problems and responsibilities of life.[4]

There was no instance where a person regarded his disability as a "cross" to be borne to atone for past sins, or for the sins of others or in some way to please God or Jesus Christ in return for the divine sacrifice for man. In one case, no religious significance was attached to the person's disability. He viewed it only as a limitation to be lived with and an obstacle to be overcome in striving for attitudes and a way of life which he set as goals.

Mature religious faith was exhibited in the ability to trust in God regardless of circumstances and in the belief that He never expects the impossible. There seemed to be two main answers to the basic questions concerning God and suffering which arose following injury. Where injury was regarded as God's will, the person felt it must be for some good purpose and this made it easier to accept the limitations. Where it was not regarded as God's will, the person felt that to interpret the disability as evidence of God's vindictiveness was contrary to the teaching of Jesus and the New Testament writers.[5]

---

[4]See also, Charles E. Palmer, *Religion and Rehabilitation* (Springfield, IL: Thomas, 1968), Chapter VII, pp. 134-184.

[5]*Ibid.*, pp. 60 and 138.

Such erroneous interpretation was derived in part from Old Testament and primitive cultural attitudes towards the maimed and disabled, and from a misunderstanding of the codification of disqualifications of the physically imperfect and impaired for the priesthood contained in the Book of Leviticus, Chapter 21.[6]

Finally, religious faith was seen to be valuable as a resource in assisting the person with spinal cord injury to deal constructively with his existential anxiety and the problem of finitude.

3. Results of the Values Questionnaire[7]

This fifteen-item instrument was formulated by Douglas Heath to measure the maturity of a person's values in terms of Heath's own model of maturing.[8] It was administered to the twelve persons with spinal cord injury selected for this study and was designed to expand and amplify on answers to the questions presented in the Interview Questionnaire concerning changes in Values and Social Attitudes under Life-Style Category L.S. (8).[9]

---

[6]The author has researched the problem of stigma and ostracism affecting the irreversibly disabled in an unpublished seminar paper, "Cultural and Social Expectations and Attitudes *vis-à-vis* irreversible Physical Disability," presented at Casa Colina Rehabilitation Center, Pomona, California, February, 1971. See also 1) Marjorie Kellogg, *Tell Me that You Love Me, Junie Moon* (New York: Popular Library, 1968); and 2) Erving Goffman, *Stigma* (Englewood Cliffs: Prentice-Hall, 1963).

[7]See Appendix C, p. 236.

[8]See Douglas H. Heath, *Growing Up in College* (San Francisco: Jossey-Bass, 1968).

[9]See *ante*, p. 181f. and Appendix A, p. 232.

A sample graph of results from four of the subjects is contained in Appendix C, p. 240. While it is not intended to analyze the results in detail, attention is drawn to those which apply to Len and Jan, the subjects presented in the Self-World Reviews.[10]

Consistent with the reports in those reviews and with the results recorded in the sample score graphs of the Self-Insight Questionnaire in Appendix D, pp. 251 and 252 , Len is shown as being confident in his feelings about social and ethical problems important to him (item 1), readily able to explain what he believes he does about an issue (5), predictable to others about his opinions (6), able to accomplish goals (7), able to describe his values and beliefs easily (10), discontented with any inconsistency or contradiction in his values and beliefs (12), seldom influenced in his values and beliefs by immediate desires and impulses (14) and realistic about the non-achievement of some of his goals (15).

Also consistent with the reports in the Self-World Review and the results of the Self-Insight Questionnaire, Jan was depicted as being uncertain in her feelings about important ethical and social problems (item 1), impulsive with resultant contradictory behavior (2), cautious and dependent (3 and 4), unpredictable to others concerning her opinions (6), unable readily to describe her values and beliefs (10), lacking guidance by any fundamental attitudes or convictions giving meaning to her life (11), not motivated to correct any inconsistencies or contradictions in her values and behavior (12), and

---

[10]See *ante*, p. 191f. and 199f. respectively.

allowing her values and beliefs to be influenced frequently by her immediate impulses and desires.

The results indicate the importance of value changes to the person with spinal cord injury in the process of his adjustment to disability. Man's fundamental problem is perceived by Rollo May and others as a loss of meaning in life.[11] Abraham Maslow also describes the spiritual yearning in our twentieth-century which knows no satisfaction.[12] Paul Tillich regards human awareness of meaninglessness as not being the basic problem, but only one expression of the larger existential issue of finitude and man's need for a personal faith and positive system of values which will help him live courageously in the face of all expressions of his finitude.[13] Viktor Frankl holds the theory that man's central longing and his original, greatest striving, is his "will to meaning."[14] Man discovers this through creative, experiential and attitudinal values.

The person with spinal cord injury, however, is largely unable because of his disability to achieve goals and accomplish tasks through the realization of creative values. He is also limited in experiential values involving the experience of the good, the true and

---

[11]Rollo May, *Man's Search for Himself* (New York: Norton, 1953), pp. 13-14.

[12]See Abraham Maslow, *Religion, Values and Peak Experiences* (Columbus: Ohio State University Press, 1964), pp. 38f.

[13]Paul Tillich, *Systematic Theology* (Chicago: University of Chicago Press, 1963), III, 130.

[14]Viktor Frankl, *The Doctor and the Soul* (New York: Knopf, 1955), pp. 37-38.

the beautiful. But through attitudinal values he can face disability and distress with the courage to be. This essentially spiritual quality which makes man "human" enables him to unite all the factors of his being in a commitment to a system of values which gives him moral strength and a perspective for understanding himself and his world.[15] This makes him mature in the task of becoming. A lack of commitment to an integrative, inclusive system of values leads to characteristics of immature behavior, e.g., lack of direction, instability, over-conformity, rebellion against authority, indecision, underachievement, playing games and wearing masks in relating to others, and inconsistency.

From the Interview Questionnaires (Life-Style Category L.S. 8) it was revealed that in a few cases where the person felt shame and inferiority in his disabled state he tended to avoid identification as a person with disability, to withdraw from society so as to escape a rebuff, and to try to outdo himself in maintaining "normal" standards.[16] If, despite his disability, he was able to feel secure as a complete, worthy individual then he could admit the difference and accept it as non-devaluating. Such admission would carry the obligation of altering his behavior, including the surrender of any methods of compulsive achievement.

---

[15]Alice B. Morrisey, "Psychosocial and Spiritual Factors in Rehabilitation," *American Journal of Nursing*, L:12 (December 1950), 763-766.

[16]For an excellent discussion see Helen Merrell Lynd, *On Shame and the Search for Identity* (New York: Harcourt, Brace and World, 1958).

Several interviewees disclosed that, in the process of adjusting to their disability, they had enlarged their scope of values following the emotional and intellectual realization that other residual values existed on which they could capitalize. In exploring alternatives they ceased to regard themselves as burdens, as empty and worthless, and began to reach out to others.

Some indicated a transformation of comparative values into asset values. In comparing their condition with that of others they became aware that the latter were worse off and so they began to take pride in remaining values. Of course, additional factors in motivating them in this direction included that of satiation ("you can only be depressed so long, then you have to 'snap out of it' and look for something new"), and a shift to the reality of the 'here and now' situation. There was also an incentive to become involved in the necessities of existence including mastery of the activities of daily living.

A few of the interviewees mentioned that, while they did not doubt the worthwhileness of their lives, they were still troubled by the supreme value placed by the activist society on physical competence and normality. This tended to make them feel degraded and that they were falling below standards. Where they were able to subordinate physique, physical appearance and ability and achievement became of relatively minor value and they were convinced of the importance of kindness, wisdom, cooperativeness, etc. as personality values, the cultivation of which would enhance their character development.

Body-image is partly a social phenomenon and most of the

interviewees alluded to its importance in the process of their readjustment of values following their disability. Several stated that, because in the popular mind conformity and belonging is so highly valued, people tended to regard the person with spinal cord injury as "different" and even "strange." This often meant being "set apart" in interpersonal relationships and, in extreme instances, could amount to rejection. No one wants to be different. The person's atypical physique sometimes created uneasiness in others, especially if they were insecure because to them spinal cord injury does not fit with a well-ordered body-image. Where disidentification was possible and actually took place the person was then regarded by others as a person with disability and not as a disabled person. In this event body-image assumed less prominence.[17]

Some interviewees alluded to the additional problems arising from the phenomenon of "spread" where the disability of the person with spinal cord injury was seen to extend not only to other physical aspects of the person but to his total person. In a few cases maladjustive reactions resulted in the person's attempt to escape possible intolerable rejection. But where adjustment to disability and a shift in values was successful the person was better able to contain the effects of his disability and to be comfortable in his differentness.

---

[17]For reasons of space body-image cannot be discussed extensively in this dissertation, but the reader is referred to the following: Paul Schilder, *The Image and Appearance of the Human Body* (New York: Columbia University Press, 1942), and M. Merleau-Ponty, *Phenomenology of Perception* (New York: Harper & Row, 1962).

CHAPTER VI

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

A. SUMMARY

In this section of the dissertation some general comments will be made in summary form concerning comprehensive features held either in common or by way of variation among the twelve persons in the category of spinal cord injury who were interviewed for the purpose of this study.

All the interviewees had come originally from reasonably stable family environments and had developed and maintained good rapport with parents and siblings. The general effect of the devastating event had been to consolidate and intensify family solidarity, with corresponding growth of ego strength in the interviewees. In one or two cases, there had been experience of perceived rejection from former friends, mainly on the basis of ignorance and embarrassment. Removal from the area to another environment had resulted in the formation of new friendships which had proved to be both positive and supportive.

In most cases, the interviewees recognized within themselves a very definite life thrust pushing them towards actualizing their potentials as worthful human beings. None, however, underestimated the difficulties involved in perseverance and listed the following factors (inter alia) which militated against this:

(1) recurring physical pain, bodily exhaustion and deterioration.

(2) decubiti (pressure sores); urinary tract failure; urological problems.

(3) immobility generally; transfer problems with wheelchairs, etc.

(4) recurring depression; occasional boredom.

(5) feelings of helplessness; fatalism, hopelessness.

(6) anxieties concerning advancing age, responsibilities and vocational opportunities.

(7) sense of loneliness and alienation from other persons and society.

(8) imagined loss of self-respect; feeling judged as inferior beings by others because of inability to cope with feelings.

(9) tendencies towards negative dependency.

(10) enquiries concerning business opportunities: receiving such answers as, "cripples couldn't handle that; they're not good financial risks," etc.

In all there was a deep longing for a sense of relatedness to other persons and for a fuller experience of life. Once having accepted their "differentness," they reached the point where they felt their lives either had to change direction or they would be in danger of giving up the will to live. It became a choice between vegetation, self-pity and eventual self-destruction as against self-affirmation, self-creativity and self-transcendence. The operative words in the experience of all were: "When I decided to . . ." Most experienced in the initial stages of trauma and rehabilitation a tendency to deny

the permanency of their condition and to refuse to accept their finitude and to withdraw from involvement as an expression of imagined release from fears, worries and stressful situations. Others clung to negative self-destructive pre-morbid behavior in order to manipulate others in an intensified effort to get attention. All experienced the frustration of lack of movement, especially those very physically oriented. Concerning sport, several have become avid spectators rather than active participants, and a few have found outlets in coaching. Several consciously resisted identification with other disabled persons and hated being stereotyped, or categorized; also any patronizing attitudes. Concerning dependency, some felt there was a danger in thinking it was easier to get others to do things for one: eventually the disabled had to fend for himself; on the other hand, many disliked admitting the need even for positive dependency. There was a continuing need for stimulation to avoid losing momentum and regressing, "giving up the fight and sitting back, just watching the world go by." Willingness to venture, take risks within reason, even to the point of failure, becoming healthily aggressive and cultivating self-discipline were all seen to be necessary factors in successful rehabilitation.

Some of the interviewees were convinced that "the world has no favorites, and it is a case of looking after Number One." Concerning suggested minority group status within the community, most felt that this was not so much a case of feeling inferior as realizing that they were comparatively few in numbers in proportion to the able-bodied. All wished to assume responsibility as full members of society; they

disliked the thought of special concessions or preferential treatment and responded to the challenge of competition in many fields. They were unanimously averse to the idea of assuming any special role in coping within society and wanted to "be themselves and not act out a part." Many took the initiative in putting other people at ease in social contexts. Most admitted that they couldn't avoid suffering which was an integral part of disability, and necessary for self-discovery and the incentive to go on trying. One interviewee at least strongly alleged some discrimination against persons with disability. "They treat us as though we don't exist; no plans are made with us in mind as an identifiable group in society . . . no consultation is held in city planning to find out our needs. . . . architectural barriers still exist, and it is discouraging to read of condescending attitudes in the literature . . . it's not fair . . . that is not where we are or want to be . . ." (He cited an instance of blind people learning to get a job stuffing fluorescent tubes in boxes and sealing them for mailing.) "This is perpetuating our dehumanization! . . . there's a false assumption that disabled persons need to be taken care of and be given a little something to keep their hands busy . . . some people have said to me 'It's nice you can get out occasionally to get a little fresh air' . . . but we're not cooped up!"

While several did not want to be treated as "special," they would appreciate the equalizing of opportunities, especially concerning provisions for access to buildings, etc. In some cases, groups of disabled persons had taken aggressive action for improvements in their

living and working conditions, e.g. formation of the "GOODS" (Grand Old Order of Disabled Students) society on the University of California, Riverside campus, whose aim is to reduce architectural barriers, etc. One interviewee expressed the wish that people would treat him automatically as a person in his own right on a first time basis without over-reacting. Visiting a restaurant with a girl friend, the waiter asked the girl: "What would the gentleman like?" "Most people are not used to breaking ice with a person with a disability . . . Adults especially are evasive and unaware of the potential of disabled people . . . they play games and try to cheer us up, projecting on to us their own hang-ups. . . . children are more natural and direct." Several single interviewees spoke of the necessity to break symbiotic relationships in order to achieve autonomy and maturity; also their resentment towards parents for their non-acknowledgment of their thrust towards independence and for their over-protectiveness from the realities of life. Some admitted to unrealistic expectations concerning their capabilities as an expression of denial of finitude and to harboring hopes for a "miracle" to happen to restore their functionality. One person, a Vietnam war veteran, admitted to immature behavior in drinking and taking drugs, despite the dangers involved in precipitating decubiti, etc. "I had to learn the hard way." In that case, the person had to experience further self-destructive episodes before assuming responsibility for his proper health maintenance in a paraplegic condition. Another paraplegic stated categorically that: "I don't want to hear 'success' stories . . . you're really telling me

'Live up to that' . . . I don't want that sort of pressure."

There was a general consensus among the twelve interviewees that they felt the benefit of the rehabilitation program and realized the importance of good motivation, despite some initial resistance to certain forms of treatment. Several agreed that they had sometimes thought of leaving the center prematurely through fear of becoming too dependent, but had experienced ambivalence in risking themselves and making their own way in the outside community. Here there appeared the need for maintaining a certain tension between freedom and destiny and between freedom and responsibility. In Casa Colina Rehabilitative Center, as in other therapeutic communities for physical treatment, the comprehensive program is designed to facilitate maximal functionality, to overcome negative dependency and to develop in persons with disability responsibility for decision-making so that they may become creative, whole human beings with potential for increased maturity. While nothing conclusive can be presumed on the basis of the interviews with these twelve persons, the factors mentioned would appear to be significant for any further studies of a larger population. The adapted version of Heath's Self-Insight Questionnaire outlined in the Appendix has been used expressly to survey the degree of maturity or immaturity achieved by each individual and for the purpose of indicating progress or otherwise towards rehabilitation in the outside community.

B. CONCLUSIONS

This dissertation has attempted through the presentation of

data from the Person-World reviews and other sources (1) to illustrate the intensified awareness of the person with spinal cord injury of his need to be affirmed as worthful in his differentness, (2) to stress the necessity of his acceptance of such affirmation, and (3) to demonstrate the importance of the communication to, and reception by, him of the essential message of the Christian Gospel as an indispensable factor in his successful rehabilitation as a member of the human community. It is submitted that the research results have validated substantially the hypothesis advanced on page 5.

To a limited degree, this study has shown the value of the onto-theological insights of Paul Tillich for an intelligent understanding of the phenomenon of spinal cord injury and has illustrated these insights by means of clinical interview materials of persons with permanent disability. Tillich's ontology was used as the foundation for an understanding of man in his "differentness" together with his ontology of love which presupposes a basic need of affirmation of one's worth from other persons. Tillich maintains that an ontology which stresses the life processes and their ambiguities is essential in understanding man and developing a suitable psychotherapeutic theory.[1]

Agape love has been advanced as the sole power sufficient to overcome man's existential separation and estrangement within himself, between himself and other human beings and between himself and the Ultimate Ground of Being. The acceptance and actualization of this

---

[1]Paul Tillich, "Existentialism, Psychotherapy and the Nature of Man," *Pastoral Psychology,* XI:105 (June 1960), 13.

love as unconditional affirmation of his self-worth by others implies a person's courage to live in the face of his finiteness expressed as death or other forms of non-being. It also enables him to become a self-integrative, self-creative and self-transcendent being capable of growth and mature behavior. In cases where persons realized their finiteness, but yet feared non-confirmation of their self-worth, and did not accept their acceptance as finite beings by others, this was observed to result in self-disintegration, self-destruction and self-profanization. These were described as immaturity in the adapted Self-Insight Questionnaire illustrating Heath's test of emotional maturity and immaturity.

Throughout the study, maturity was seen as a combination of love and courage founded on the unconditional Love of Being as being which receives its power from the *theos* of *ontos* itself. This Power of Being which is inherent in the core of all being is at work in all being to "*in*-courage" it to realize its own potential and to become truly integrated with its Ground of Being. Entry into the New Being which is grasped by the Power of Being allows the person to feel secure and comfortable in his finiteness and to risk making extremely ambiguous decisions without fear of being immobilized or denying the inherent tension between freedom and destiny.

The spinal cord injury person who experiences New Being is able to cope with the anxiety of possible non-being and, by living with and in spite of this threat, strengthen and reinforce his own self-affirmation. He can risk himself more in loving others with a

sense of greater individuation and relatedness which in turn augments his powers of self-creativity and self-transcendence. Here the ontology of dynamic *agape* love is seen as a powerful interchange of constant movement between human beings and beyond human beings to the Ground of all Being, from which it returns to them.

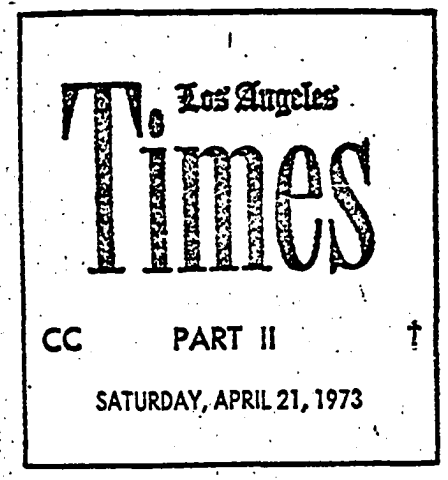
Finally, some general observations are now made from information gained from the Self-World Interviews.

Concerning Comprehensive Rehabilitation of the irreversibly physically disabled it was considered by several interviewees that the greatest need of the person with spinal cord injury was to receive more feedback from others, to have reassurance and guidance in getting used to his "differentness" and in aiming for equilibrium in his struggle towards positive dependency. Many felt during their hospitalization a need for someone (not necessarily professional staff) to talk to informally, of more time to absorb and realize what had happened and to learn things for themselves, even from their own mistakes. Some felt that the physical treatment programs were too high-powered; they demanded too much too soon and ought to be balanced by more emotional help. A few suggested the establishment of a Half-Way house following discharge from the rehabilitation center as an easier means of transition back into the community. The appointment of an ombudsman, preferably a patient, to act as a liaison between staff and patients was also suggested (this is the case at present at Casa Colina Center).

Concerning the attitude of the public towards the phenomenon,

it was generally thought that persons without disability were afraid of it, mainly through apathy or ignorance. There was a tendency to regard it as a form of "partial death." People were not facing the issue realistically. More contact on a regular basis between them and persons with spinal cord injury in a non-structured setting was felt to be needed. The persons with disability felt they needed to be noticed or at least recognized as part of the human family and not as "freaks." There seems to be a serious ignorance on the part of the general public concerning the physiological aspects of spinal cord injury and the emergency methods to be used where the disabled person required help, e.g. when falling out of a wheelchair, etc. Since most people know what to do about broken bones, the approach "You've got a spinal cord too and ought to know something about it" might alleviate some of the ignorance and confusion. Most people imagine that if a person's neck is broken, he doesn't live after that. The public also needs to be aware of the existence of permanently disabled individuals as persons, with the same hopes, fears, goals, interests and aspirations--the "differentness" is only a matter of degree. Persons without disability ought to realize that all spinal cord injury people are not disabled in the same manner and that the extent of disability is determined by the level of injury. The consensus was that the best means of educating the public was to teach children early in the schools the nature and meaning of permanent physical disability. Concerning suggestions of inferiority status as a minority group in society, most of the interviewees discounted this, but agreed that

persons with spinal cord injury ought to become more visible in the community and take more aggressive action in their own interests. However, there are occasional instances of apparent discrimination as witnessed by the following newspaper report:



PARALYTIC SUES THEATER HE SAYS TURNED HIM AWAY

Robert L. Marsh Jr., a Laguna Hills quadruplegic, Friday filed a Superior Court suit charging a Newport Beach movie theater violated his civil rights by refusing to admit him.

The suit claimed Marsh was turned away from the Edwards Newport Cinema April 21, 1972, when he appeared in a wheelchair, accompanied by his parents, to see the film "The Godfather." March claims he was refused admittance solely because he is handicapped and was denied equal protection of the law in violation of the 14th Amendment to the U.S. Constitution.

Concerning general relationships with the medical profession, in the community, the majority of the interviewees cited personal instances of having had difficulty in becoming regular patients, even for the treatment of minor ailments. They attributed this to a reluctance on the part of physicians and general practitioners to become involved with persons having permanent disability. Most of the interviewees stated that they would prefer to be treated directly and honestly without evasion as persons and not to be handled "like a hot potato," shuttle-cocked from one medico to another. Although it was

admitted on challenge that this attitude was very much a "two-way street," it was thought that it stemmed partially from lack of knowledge or apprehension, an unconscious notion that spinal cord injury is like an unknown disease and from over-specialization in medical training or gaps in the curricula of medical school programs. Whatever the reasons, the interviewees were unanimous in their expression that they would like doctors to say immediately, on consultation, "I don't know how to help you" and then refer them to someone else, but not necessarily to a specialist. It is interesting to note that Henry B. Betts, one of the nation's leaders in rehabilitation medicine and Medical Director of the Rehabilitation Institute of Chicago attached to Northwestern University Medical School, stated at an annual meeting of Casa Colina Center on June 8, 1972 that physiatrics was one of the newest specialties in medical science and practice and was still somewhat suspect in medical circles. There is a great need to disseminate information and to build bridges between rehabilitation medicine and the allied health professions.

Concerning the place of clergy in comprehensive rehabilitation, it was generally felt by the interviewees that pastors were very receptive of persons with permanent physical disability, but that they needed knowledge of the physiological and psychological aspects of the phenomenon of spinal cord injury in order to minister and counsel effectively. Charles E. Palmer has outlined very effectively and in considerable detail the role of the clergy and the local congregation in the whole area of the rehabilitation of the irreversibly physically

disabled.[2] The interviewees stressed that it is good for a congregation to realize that persons with spinal cord injury are not psychologically or spiritually different from other human beings, and that it is important to include them as participating members for a sense of Christian community to become real. Generally, church congregations are not conversant with the nature and meaning of permanent physical disability in general and spinal cord injury in particular. Architectural barriers still exist and persons with disability still feel separated physically from other persons sitting in fixed pews and when receiving communion during church services. The fact that they are usually the last to leave any building or classroom means that it takes longer and more effort for them to learn to know others and to make friends.

C. THE IMPLICATIONS OF THE STUDY FOR PASTORAL CARE AND COUNSELING

Throughout this dissertation, the proposition has been advanced that in order for the rehabilitation of the person with spinal cord injury to be complete, a comprehensive approach must be made to all problems affecting his physical, psychological, economic, educational, vocational and spiritual welfare and development. This involves an interdisciplinary task. While clinical treatments aimed at the restoration of maximal physical functioning in society are

---

[2]See Charles E. Palmer, *Religion and Rehabilitation* (Springfield, IL: Thomas, 1968), Chapters 8 and 9, pp. 185f.

vitally important, an exclusive concentration on any one or all of these without dealing with the individual as a human being--a person--would amount to treating him as an object and would militate against his best interests. The spiritual dimension of a person's life is something which cannot be discounted, and this is where the role of the pastor and pastoral counselor becomes essential in the comprehensive rehabilitation of persons with spinal cord injury.

Reference has already been made to H. J. Clinebell, Jr.'s enumeration of four basic spiritual needs in man.[3] Earlier in the same work, he mentions that a person's single, essential, indispensable personality need is to experience authentic love in a dependable relationship which involves the ability to give as well as receive love. Other derived needs include (a) a sense of his own worth, (b) responsible living, (c) inner freedom, (d) sense of meaning in life and (e) a trustful relationship with God. Satisfaction of these needs will enable him to cope with his responsibilities and problems, and to continue to grow towards the fulfillment of his unique personhood.[4]

Clinebell makes the observation that prior to the advent of Carl Rogers, pastoral counseling had been based mainly on a psychoanalytic or medical model in which man's nature was perceived either as "mental health" or "mental illness." The prescription for cure or salvation lay in attempting to reach the norms of health.[5] This was a

---

[3]Howard J. Clinebell, Jr., *Basic Types of Pastoral Counseling* (Nashville: Abingdon Press, 1966), p. 251.

[4]*Ibid.*, pp. 18-20.

[5]*Ibid.*, pp. 39-40.

departure within the pastoral counseling movement from its original rich theological heritage grounded in the Pastoral Care tradition of Seelesorge, the ministry of the cure of souls, which emphasized "helping acts, done by representative Christian persons, directed towards the healing, sustaining, guiding and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns."[6] Seward Hiltner has made a distinct contribution in his expanded treatment of these four essential functions and aspects of pastoral care which have not always been kept in balance. The Pastoral Counseling model had tended to concentrate primarily on healing and to relegate guidance to a secondary position. Paul Tillich, in discussing the relationship between counseling and theology, insists that both are functions of the Christian Church and that counseling contributes to theology as well as receiving its theoretical basis from theology.[7] Edward Thornton reinforces this contention by asserting that, although theology assists in shaping answers to the questions of human existence, growth, nature, values, etc., which emerge from counseling situations, the human experiences of crises themselves stimulate, interpret, correct, illuminate and describe a theological faith.[8] Devoid of its theological groundwork and sources, pastoral

---

[6]William A. Clebsch and Charles R. Jaekle, *Pastoral Care in Historical Perspective* (Englewood Cliffs: Prentice-Hall, 1964), p. 4.

[7]Paul Tillich, "Theology and Counseling," *Journal of Pastoral Care*, X:4 (Winter 1956), 193-200.

[8]Edward E. Thornton, *Theology and Pastoral Care* (Englewood Cliffs: Prentice-Hall, 1964), pp. 15-26.

counseling would cease to be pastoral. Each pastor or pastoral counselor by virtue of his theological training is equipped to minister and to respond to persons on the level of their ontological needs mentioned above. Because pastoral theology is the context out of which the pastor or pastoral counselor perceives persons and their experiences, every instance and act of pastoral care and counseling has implicit theological implications.

A substantial focus of this dissertation has been on the message and power of *agape* love as the norm of creative union with all that is finite and estranged. In Tillich's thought the approach to the human situation is of immense importance. It indicates one who comes to the situation, not with clear-cut formulated answers, but with an attitude and intention of partnership, of waiting and listening from within that situation. Tillich makes it abundantly clear that neither solution, meaning, nor hope comes through any attitude of detachment or separation. Thus there is a constant correlating process of the questions which arise from within the situation and the answers which may be relevant to it.

This points to the centrality of the human experience and of the relatedness of one to the other within it. Experience is the medium both of the questions of the situation and of their answers, and it may have a reality irrespective of objective observation and, indeed, in the givenness of its nature, regardless of subjective appraisal. This speaks directly to pastoral care and counseling and underlines, as Binswanger and other existentialist thinkers have

emphasized, the need for a more sympathetic appreciation of the experienced world of the particular person, and of experiential reality generally.

In his analysis of experience, Tillich discerned that certain presuppositions or patterns were implied, and these are reflected in his ontology. This ontology has relevance for pastoral counseling in that it discloses, in a systematic way, man's existentiality and points to the New Being as the sufficient answer to the threats which this existentiality contains. Tillich depicts, perhaps more clearly than others, the fundamental structures of man's being and demonstrates that in his finitude and estrangement, man, through his grandiosity, may negate and disrupt these structures. In addition, he brings a fresh insight into the categories and concepts of existence. The advantage of Tillich's approach seems to be that, whereas a psychological study deals more with the ontic and "preliminary" level of man's existence, Tillich's analysis is concerned with the ontological and "ultimate" level.

Applying the distinction he makes between existential and pathological anxiety, Tillich hastens to acknowledge that the counselor's rightful task in a psychotherapeutic setting is to alleviate the pathological condition. But he also maintains that anxiety, insofar as it is existential and ontological, can never be removed, nor should pastoral counseling attempt to do so. In its existential form it is something with which man must come to terms. But how? Tillich claims the only satisfactory answer to this existential

anxiety is the person's discovery and acceptance of divine acceptance, which in turn implies an acceptance, by faith, of the power of the New Being and a communication of this power to others.

In Tillich's view the pastoral counselor fulfills a vehicular function.[9] He must always direct the patient towards the ultimate goal of accepting the divine acceptance. The therapeutic care thus represents a preliminary stage towards this discovery of the "ultimate meaning" in which the person becomes aware of his life structure centered in God, from whom he receives the grace which he needs. This does not depreciate the achievements of psychotherapy, so long as it directs the patient towards this goal which, for Tillich, is of crucial importance. To receive what is implied in this goal is to receive rehabilitation--restoration--salvation. To lose what is implied is to lose the center of Being, and this in turn means loss of self, and loss of communal relatedness. The salient points of the approach of Tillich (and also that of Buber and Binswanger) as discussed in this study may be recapitulated as follows:

1) Its emphasis is on experience; both experiential reality in general, and the unique experience of a particular individual.
2) It seeks to discern the meaning-structures of existence and to relate the ontic level to the ontological. (Tillich)
3) The theology is theocentric; it reflects man's existentiality, but points to his despair until he is directed towards the

---

[9]Paul Tillich, *Systematic Theology* (Chicago: University of Chicago Press, 1963), I, 12-13.

ultimate meaning, the core of which is the divine life and divine grace.

4) This ontology, while pointing to man's actuality, also emphasizes his potentiality, and provides a solution whereby man can transcend the actuality of his predicament. Transcendence and self-fulfillment are marked by their givenness, and are received in man's turning toward the other with the intention of dialogue and community.

5) The emphasis of this approach is always on the unrestricted participation in the human situation.

In counseling the irreversibly physically disabled, considerable value has been found in adopting the ontological approach based on the polarities of finitude and infinitude, dynamics and form, individualization and participation, and freedom and destiny.

The concentration of pastoral counseling on the finitude-infinitude polarity helps the person with spinal cord injury to achieve self-transcendence which relates him to the Power of Being beyond himself so that he can be grasped by the transforming power of the New Being experienced as integration with his essential being. Through the experience of *agape* love he is presented with a new creativity and a new relatedness to all being which offers a healing of the existential estrangement. The "ecstacy" of the unconditional love expressed to him by another person allows him to celebrate life with that other in such a way that increased growth occurs because of the deep link with the ground of all being.

The focus of counseling on the individualization-participation polarity allows for the striking of a balance between aloofness from, and identification with, the disabled person. Through the maintenance of a "psychic distance" between himself and the other person in which he can operate within the tension of both polarities, the pastoral counselor can avoid reacting to full transference with the counselee.

Excessive rigidity or inflexibility in the counselor in the way in which he perceives the person with spinal cord injury could result in rejection of the other's identity. Here the dynamics and form polarity is important in the counseling context. Far from offering the last word in solutions of the person's problems, the counselor's task is to help the disabled to perceive new horizons in his life. Only unconditional *agape* love encourages persons to risk changes in their lives without fear of losing their centeredness.

In order to resist upsetting the balance in the freedom-destiny polarity, the counselor must avoid making all the decisions for the person with disability, who must be helped to use his limited freedom within and outside the counseling relationship in a responsible manner. Negative symbiosis in which the person transfers his dependency from significant others to the counselor must also be resisted. The aim as always is to achieve a state of positive dependency in which his worth as a person can be affirmed and his irresponsible and unloving behavior, if any, can be confronted. By assuming responsibility for himself and his decisions and asserting himself positively in community, the person with spinal cord injury can become increasingly

autonomous and individuated and can thereby actualize his life processes in self-integrative, self-creative and self-transcendent ways. It is essential in effective pastoral counseling of and ministry to the person with spinal cord injury that the counselor familiarize himself with some of the basic physiological and psychological aspects of traumatic injury together with the developmental features of adjustment to resultant disability. With a reality-oriented approach, the counselor can develop an awareness of his own feelings about spinal cord injury. E. F. Proelss, a rehabilitation chaplain, has evolved a four-phase theory of his own adjustment to persons with disability, viz. (1) experience of depression and anxiety, (2) acceptance of persons "because of" their disability, (3) acceptance of persons "in spite of" their disability (the opposite extreme) and (4) learning to accept persons "with" their disability.

Resistance to adopting a "savior" or "babying" approach which can endanger the person's autonomy while feeding the counselor's sense of omnipotence or his own dependency needs, is essential. Functioning in the role of a "savior" approximates playing God rather than acting as his representative.

The pastoral counselor working with persons with disability must also decide on the methodology and goals of his counseling ministry. As Jerome Siller, a psychologist, states:

> The aim is to assist the person toward reformulating a self that approves of continuing to be, despite important discontinuities with its first identity. Specifically, this means the promotion of a new self-image predicated on worth, rather than on deficiency and self-contempt.[10]

Franklin Duncan has expressed the long-range goal similarly:

> The great task of pastoral care is not to refashion a man but to make him conscious of his own unique, God-given capacities and values and to help him discover a meaning in life.[11]

Duncan further suggests a methodology of pastoral care and counseling of persons with spinal cord injury based on a ministry of (a) comfort (b) catalysis and (c) challenge.

Through confort the pastoral counselor communicates to the person genuine acceptance of him for who he is. Initially, he achieves this by his presence which reminds the person of God's acceptance of him and of the unconditional values and meanings in life which still remain. Comfort is expressed also by empathizing with the person's suffering, fears, despair, confusion, anger, love and courage. Through catharsis, the counselor fulfills the person's need to know that he is loved and valued by someone who is able to enter into his system of concerns and values understandingly. The reassurance and support which is offered must focus squarely on the reality of the person's situation if the pastoral counselor is to act responsibly and give the needed comfort.

---

[10]Jerome Siller, and Abram Chipman, "Attitudes of the Non-Disabled toward the Physically Disabled" (New York: New York University School of Education, 1967), p. 294.

[11]Franklin D. Duncan, "Pastoral Care of Disabled Persons," in Wayne E. Oates and Andrew D. Lester (eds.) *Pastoral Care in Crucial Human Situations* (Valley Forge: Judson Press, 1969), p. 145.

As a catalyst, through empathetic questioning, the counselor may attempt to accelerate the person's acceptance of his disability, his discovery of some vocational purpose, his assumption of responsibilities and his fulfillment of his potentialities. By the use of reflection, the person's attention can be diverted from his sense of loss and focused on what he can do or be in the future. This concentration can be produced by asking this type of "as if " question: "What do you feel life would be like if you had to be in a wheelchair from now on?"

Through a challenging approach, the pastoral counselor can assist the person with spinal cord injury to commit himself to positive goals and values, all the while respecting the person's authority and privilege to decide his own destiny. Here the counselor may have to be confronted by his own limitations, but if a warm, supportive and understanding relationship has been formed, the person may be led to a commitment by the communication to him that, however he orientates his life, it is going to make a difference to other persons and to God.

Where there is a sense of estrangement in the person through his "differentness," the counselor as the bearer of the New Being through his communication of *agape* love can become a Reconciler, along with any other person or persons, e.g. friends and professional staff, etc., who express caring concern. Empathetic listening, sensitivity and awareness that the predicament of the person with disability is not unlike his own, and only in a matter of degree, makes the counselor an encourager. Here there is affirmation of weaknesses and finitude

which produces strength. Tillich sums it up well:

> Man must accept himself in all his negativities, but he can do this only if he acknowledges that he is accepted in spite of these negativities. So acceptance always has these two sides. It does not mean that someone says to himself, 'I am weak so I accept that I am weak.' It also means 'I have the courage to accept that I am weak and in this, I am strong.'[12]

In the counseling situation the counselor touches base on the positive ontological level with his own humanity and also with that of the person with spinal cord injury. At that point, both are at one in the commonality of their humanity and needs.

The counselor is also a giver in the sense that:

> . . . creative caring is always given, never earned, and that the patient's contribution is fundamentally the acceptance of the fact that he is cared for, that he is accepted in spite of his having no claim to acceptance.[13]

The true test of the embodiment of *agape* love in persons and in community is that there can be no such thing as discrimination among persons who are the recipients of such love. The counselor is also the mediator of God's forgiveness and grace as a free gift. Within the context of the reconciling function of a counseling ministry to persons with disability this includes the inculcating of discipline expressed as confronting love to enable a person to change his self-destructive behavior and to begin to relate to others in less demanding and more giving ways.

---

[12]Paul Tillich, "The Spiritual and Theological Foundation of Pastoral Care," *Clinical Education for the Pastoral Ministry* (Advisory Committee on Pastoral Education, 1958), p. 2.

[13]Donald H. Rhoades, *A Faith for Fellowship* (Philadelphia: Westminster Press, 1965), p. 58.

Counseling and ministering to persons with spinal cord injury is and remains a challenging task and privilege, requiring not only concern but also skill. E. Frederick Proelss summarizes it well:

> The greatest service the pastor can offer the disabled is to walk with him through the valley of anguish, depression, and anger; to stand at his side in the struggle with confusions and doubts; to work with him toward a new inner balance, as well as toward a realistic acceptance and accommodation of what the future will hold for him, and to do all of this in the spirit and as the representative of the community of the faithful.[14]

D. RECOMMENDATIONS FOR FURTHER RESEARCH

Arising from observations made in the course of this research, some additional studies are suggested for consideration.

1. The study of a larger population or a small homogeneous group of persons with spinal cord injury might seek to determine the reactions of family members to the trauma and their influence on rehabilitation. To the writer's knowledge, no study has been made on the possible use of techniques similar to the Alanon approach for the benefit of dependents.
2. More research needs to be done in the following areas:
   a) to test the hypothesis that persons with spinal cord injury are viewed in certain ways as minority group members using, e.g., analysis of correlates of attitudes toward blindness;
   b) to explore any one of the concepts of body-image, human sexuality and personality change, and the approaches of marriage

---

[14] E. Frederick Proelss, "Ministering to the Physically Disabled Person," *Pastoral Psychology*, XVI (June 1965), 8-22.

counseling and group therapy as they affect this human phenomenon;

c) to examine the implications of the phenomenon of "spread" as it applies to spinal cord injury;

d) to explore into the self-imposed chosen aspects of disability, escapism, the dynamics of martyrdom and death-seeking in spinal cord trauma;

e) to study the phenomenon from a Jungian typological or a Gestaltist approach;

f) to determine through the use of appropriate research instruments administered to persons with spinal cord injury the shifts in their personal values and the changes in the structure and intensity of their religious faith, not just changes in the contents of their individual beliefs, as was the case in the research of Jack E. Briersdorf and John R. Johnson, Jr.[15] Here Douglas Heath's Values (PSQ) Questionnaire, and Merton Strommen's research on religious development could provide useful resources;

g) to examine the more practical aspects and elements of a rehabilitation center treatment program for persons with spinal cord

---

[15]See Jack E. Briersdorf and John R. Johnson, Jr., "Religion & Physical Disability," *Rehabilitation Record*, VII:1 (January-February, 1966), 1-4. Douglas H. Heath, *Growing Up in College* (San Francisco: Jossey-Bass, 1968). Merton Strommen, *Research on Religious Development: A Comprehensive Handbook*. A project of the Religious Education Association (New York: Hawthorn Books, 1971).

injury to determine its qualification to be styled as a community of faith, hope and love in which, to use Tillich's terminology, the 'New Being' is actualized. A similar survey study could be used in respect of a local congregation or ecumenical group of congregations;

h) to apply Tillich's ontological insights in a clinical setting with a view to developing a specific type of therapeutic approach to spinal cord injury with the possible designation: "Being and Becoming" therapy.[16]

3. A research project could be undertaken to compare the positions of married and single persons with spinal cord injury during rehabilitation.

> The hypothesis that single persons make greater progress away from their parents' home where the necessary transition from 'sick' to 'different' occurs more slowly and less effectively, would need to be proved or disproved.

4. A longitudinal study could be undertaken with a larger sample and with in-depth interviews conducted at specific intervals (from the onset of the trauma through the rehabilitation treatment period until, say, a year after discharge as an out-patient) to measure growth and maturity of the persons concerned. While there would be logistic difficulties, such research would be valuable in the

---

[16] I am indebted here for the suggestions made in the research of Jack B. Harrison, "Paul Tillich and Psychotherapy," (unpublished Th.D. dissertation, School of Theology at Claremont, 1967); also Sam L. Slack, "An Understanding of Compulsive Drug Abuse from an Onto-Theological Concept of Man as Illustrated by Interview Studies of Compulsive Drug Abusers from Crisis House," (unpublished Th.D. Dissertation, School of Theology at Claremont, June 1972).

following investigative areas:

a) to afford insight into whether increases or decreases in social or recreational activities of persons with spinal cord injury would continue with resultant adjustment in self-concept (identity) and life style;

b) to determine the resolution or non-resolution of changes in the life-style category of sexual behavior as it affects male and female persons with spinal cord injury;

c) to test the hypothesis that covert changes precede overt changes, i.e., shifts in the foci of the person's self-image precede the changing of life-styles or the reverse hypothesis that changes in overt behavior as a function of the spinal cord injury state foster changes in the person's perceptions, feelings and attitudes. Here the Self-Concept and Life-Style categories of the same subjects would be compared against each other at various time points in the rehabilitation experience over an extended period;

d) to test an emerging hypothesis concerning the role of counseling in spinal cord injury, viz., "that counseling tends to move persons with permanent physical disability in the direction of an independent, responsible stance towards life in contrast to a possible dependent attitude, since counseling forces them to face the reality of their condition and to make self-affirming choices." This could be tested by means of comparative responses to categories related to vocational orientation

behavior and personal goals.

From the foregoing it will be seen that the phenomenon of spinal cord injury within the total context of irreversible physical disability is wide open to sound and independent empirical observation and research.

EPILOGUE

From the information gleaned in this study, it becomes evident that the basis of any pastoral counseling research on an inter-disciplinary level stands or falls on factual, naturalistic observations, concise but accurate record keeping, and an appreciation of the process of human growth and development. Robert White[17] calls this "the study of lives in progress," and B. F. Skinner terms it the "cumulative record."[18] Applied to the study of persons with spinal cord injury, it is a dynamic, experiential task involving supremely the communication of faith, hope and love to persons who face the unalterable, the unknown or the frightening. To some extent, the foregoing chapters of this dissertation attempt to call attention to the prominent place which this triad of essential elements in human experience occupies in human existential crises such as irreversible physical disability.

The focus throughout has been not so much on the phenomenon of massive physical disability as on the persons themselves. In

---

[17]Robert W. White, *Lives in Progress* (New York: Holt, Rinehart and Winston, 1961).

[18]B. F. Skinner, *Cumulative Record* (New York: Appleton-Century-Crofts, 1952), p. 4.

onto-theological terms they may be regarded as "different," but as in the case of persons without disability, they also face in a very real sense the experience of their finitude as human beings in the threat of self-loss and loss of being expressed in environmental support. Only the communication and acceptance of *agape* love from others can overcome the denial of their finitude and avoid the pain of possible rejection feared in loss of being in interpersonal relationships and the community. This is and will always remain the primary task of all engaged in the pastoral ministry and pastoral counseling to those with permanent physical disability: to encourage the actualization of unique personhood, despite physical limitations, as a free, consistent, maturing human being, living courageously in the context of affirming relationships and community and being loved by the Ultimate Ground of all Being.

BIBLIOGRAPHY

A. BOOKS

ACKERMAN, Nathan. *The Psychodynamics of Family Life:* Diagnosis and Treatment of Family Relationships. New York: Basic Books, 1958.

ALLPORT, Gordon W. *Individual and His Religion.* New York: Macmillan, 1951.

_____. *Use of Personal Documents in Psychological Science.* New York: Social Science Research Council, 1942.

_____. *Pattern and Growth in Personality.* New York: Holt, Rinehart and Winston, 1961.

ARGYLE, Michael. *Social Interaction.* New York: Atherton Press, 1969.

ASSAGIOLI, Roberto. *Psychosynthesis:* A Manual of Principles and Techniques. New York: Hobbs, Dorman, 1965.

BINGHAM, Walter van Dyke, and Victor Moore Bruce. *How to Interview.* New York: Harper & Bros., 1959.

BOISEN, Anton T. *The Exploration of the Inner World.* New York: Harper & Row, 1936.

BROWN, D. MacKenzie. *Ultimate Concern:* Tillich in Dialogue. New York: Harper & Bros., 1965.

BUBER, Martin. *Between Man and Man.* Trans. by R. Gregor Smith. London: Routledge and Kegan Paul, 1947.

_____. *Eclipse of God.* London: Gollancz, 1953.

_____. *I and Thou.* Trans. by R. Gregor Smith. Edinburgh: Clark, 1937.

_____. *Mamre.* Trans. by G. Hoat. Melbourne: University of Melbourne Press, 1946.

_____. *Pointing the Way:* Collected Essays. Trans. and ed. by Maurice Friedman. London: Routledge and Kegan Paul, 1947.

_____. *Two Types of Faith.* London: Routledge & Kegan Paul, 1951.

BUGENTAL, James F. T. (ed.) *Challenges of Humanistic Psychology.* New York: McGraw-Hill, 1967.

CLEBSCH, William A., and Charles R. Jaekle. *Pastoral Care in Historical Perspective.* Englewood Cliffs: Prentice-Hall, 1964.

CLINEBELL, Howard J., Jr. *Basic Types of Pastoral Counseling*. Nashville: Abingdon Press, 1966.

COBB, John B., Jr. *The Structure of Christian Experience*. Philadelphia: Westminster Press, 1967.

ERIKSON, Erik H. *Gandhi's Truth*. New York: Norton, 1969.

_____. *Childhood and Society*. New York: Norton, 1963.

_____. *Young Man Luther*. New York: Norton, 1958.

_____. *Identity and the Life Cycle*. (Psychological Issues. Vol. I, No. I, Monograph I.) New York: International Universities Press, 1959.

_____. *Identity: Youth and Crisis*. New York: Norton, 1968.

FIELD, Minna. *Patients are People*. 3d ed. New York: Columbia University Press, 1967.

FRANKL, Viktor E. *The Doctor and the Soul*. New York: Knopf, 1955.

_____. *The Will to Meaning*. New York: World, 1969.

FREUD, Sigmund. *The Complete Works of Sigmund Freud*. Standard Edition. Ed. by James Strachey. 24 Vols. London: Hogarth Press, 1957.

FRIEDMAN, Maurice. *To Deny Our Nothingness*. New York: Holt, Rinehart and Winston, 1941.

FROMM, Erich. *Escape from Freedom*. New York: Holt, Rinehart and Winston, 1941.

_____, and Ramón Xirau. *The Nature of Man*. New York: Macmillan, 1968.

GLASSER, William. *Reality Therapy*. New York: Harper & Row, 1965.

GOFFMAN, Erving. *Presentation of the Self in Everyday Life*. New York: Doubleday, 1959.

_____. *Stigma:* Notes on the Management of Spoiled Identity. Englewood Cliffs: Prentice-Hall, 1963.

GOLDBRUNNER, Joseph. *Holiness is Wholeness*. New York: Pantheon, 1955.

GRIMSLEY, R. *Existentialist Thought*. Cardiff: University of Wales Press, 1955.

GRINKER, Roy R., and John P. Spiegel. *Men Under Stress*. Philadelphia: Blackston, 1945.

HACHIYA, Michihiko. *Hiroshima Diary*. Trans. and ed. by Warner Wells. Chapel Hill: University of North Carolina Press, 1955.

HAMILTON, K. W. *Counseling the Handicapped in the Rehabilitation Process*. New York: Ronald Press, 1950.

HEATH, Douglas H. *Exploration of Maturity*. New York: Appleton-Century-Crofts, 1965.

_____. *Growing Up in College:* Liberal Education and Maturity. San Francisco: Jossey-Bass, 1968.

HEIDEGGER, Martin. *Identity and Difference*. New York: Harper & Row, 1969.

HILL, Joseph E., and August Kerber. *Models, Methods and Analytical Procedures in Educational Research*. Detroit: Wayne State University Press, 1967.

HILTNER, Seward. *Religion and Health*. New York: Macmillan, 1943.

HOWE, Reuel L. *The Creative Years*. Greenwich, CO: Seabury Press, 1959.

_____, and Karl Menninger, (eds.) *Constructive Aspects of Anxiety*. Nashville: Abingdon Press, 1963.

JOSEPHASON, Eric and Mary (eds.) *Man Alone*. New York: Dell, 1962.

KAHN, Robert L., and Charles F. Cannell. *The Dynamics of Interviewing*. New York: Wiley, 1957.

KEDGLEY, C. W., and R. W. Brettall, (eds.) *The Theology of Paul Tillich*. New York: Macmillan, 1952.

KELLOGG, Marjorie. *Tell Me That You Love Me, Junie Moon*. New York: Popular Library, 1968.

KENISTON, Kenneth. *The Young Radicals*. New York: Harcourt, Brace & World, 1968.

_____. *The Uncommitted*. New York: Harcourt, Brace, 1965.

KLEINMUNTZ, Benjamin. *Personality Measurement*. Homewood, IL: Dorsey Press, 1967.

KÜBLER-ROSS, E. *On Death and Dying*. New York: Macmillan, 1969.

LAING, R. D. *The Politics of Experience*. New York: Pantheon, 1967.

_____. *The Divided Self*. New York: Pantheon, 1969.

_____, *et al*. *Interpersonal Perception*. A Theory and Method of Research. New York: Springer, 1966.

LANDIS, C., and M. M. Bolles. *Personality and Sexuality of the Physically Handicapped*. London: Hoeber, 1942.

LYNCH, William F. *Images of Hope*. Baltimore: Helicon Press, 1965.

LYND, Helen Merrell. *On Shame and the Search for Identity*. New York: Harcourt, Brace & World, 1958.

MASLOW, Abraham H. *Motivation and Personality*. New York: Harper & Bros., 1954.

_____. *Religion, Values and Peak Experiences*. Columbus: Ohio State University Press, 1964.

_____. *Toward a Psychology of Being*. Princeton: Van Nostrand, 1962.

MATSON, Floyd W., (ed.) *Being, Becoming and Behavior*. New York: Braziller, 1967.

MAY, Rollo. *Existence*. New York: Simon and Schuster, 1958.

_____, (ed.) *Existential Psychology*. New York: Random House, 1961.

_____. *Man's Search for Himself*. New York: Norton, 1953.

_____. *The Meaning of Anxiety*. New York: Ronald Press, 1953.

_____. *Psychology and the Human Dilemma*. Princeton: Van Nostrand, 1967.

MCDANIEL, James W. *Physical Disability and Human Behavior*. New York: Permagon Press, 1969.

MCQUARRIE, John. *An Existential Theology*--A Comparison of Heidegger and Bultmann. London: S.C.M. Press, 1955.

MENNINGER, Karl. *The Vital Balance*. New York: Viking, 1963.

MERLEAU-PONTY, M. *Phenomenology of Perception.* Trans. by Colin Smith. New York: Harper & Row, 1962.

MINUCHIN, Salvador, *et al. Families of the Slums.* New York: Basic, 1967.

MOUSTAKAS, Clark E. *Loneliness.* Englewood Cliffs: Prentice-Hall, 1961.

NAGI, S. Z. *Disability and Rehabilitation.* Columbus: Ohio State University Press, 1969.

NEL, Barend F. *A Phenomenological Approach to the Problems of Youth.* (Education Studies by the Worth Community for Advancement of Pedagogy as a Science, V. 8, No. 27.) Pretoria, South Africa: University of Pretoria Press, 1960.

NIEBUHR, Reinhold. *The Nature and Destiny of Man:* A Christian Interpretation. 2 vols. New York: Charles Scribner's Sons, 1941.

OATES, Wayne E. *Anxiety in Christian Experience.* Philadelphia: Westminster Press, 1955.

ODEN, Thomas C. *Contemporary Theology and Psychotherapy.* Philadelphia: Westminster Press, 1967.

_____. *Kerygma and Counseling.* Philadelphia: Westminster Press, 1966.

_____. *The Structure of Awareness.* Nashville: Abingdon Press, 1969.

OUTLER, Albert. *Psychotherapy and the Christian Message.* New York: Harper & Row, 1954.

PALMER, Charles E. *Religion and Rehabilitation.* Springfield, IL: Thomas, 1968.

PERLS, Fritz. *Gestalt Therapy Verbatim.* Lafayette, CA: Real People's Press, 1969.

PIAGET, J. *The Psychology of Intelligence.* New York: Harcourt, Brace & World, 1950.

PRESSEY, Sidney L., and Raymond G. Kuhlen. *Psychological Development Through the Life Span.* New York: Harper & Row, 1957.

PROGOFF, Ira. *The Symbolic and the Real.* New York: Julian Press, 1963.

REIK, Theodore. *Psychology of Sex Relations*. New York: Grove Press, 1945.

RHOADES, Donald H. *A Faith for Fellowship*. Philadelphia: Westminster Press, 1965.

RICHARDSON, Stephen A., Barbara Snell Dohrenwend, and David Klein. *Interviewing:* Its Forms and Functions. New York: Basic, 1965.

ROGERS, Carl R. *On Becoming a Person*. Boston: Houghton Mifflin, 1961.

_____. *Client-Centered Therapy*. Boston: Houghton Mifflin, 1951.

_____, and Barry Stevens, (eds.) *Person to Person:* The Problem of Being Human. Walnut Creek, CA: Real People's Press, 1967.

ROTH, Julius A., and Elizabeth M. Eddy. *Rehabilitation for the Unwanted*. New York: Atherton Press, 1967.

RUESCH, Jurgen. *Chronic Disease and Psychological Invalidism*. Berkeley: University of California Press, 1951.

RUSK, Howard A. *Primer for Paraplegics and Quadriplegics*. New York: Institute for Physical Medicine and Rehabilitation, New York University Medical Center, 1960.

_____, and Eugene J. Taylor. *Living with a Disability*. Garden City: Blackiston, 1953.

_____. *New Hope for the Handicapped*. New York: Harper & Bros., 1948.

SADLER, William A., Jr. *Existence and Love*. New York: Charles Scribner's Sons, 1969.

SARANO, Jacques. *The Meaning of the Body*. Trans. by James H. Farley. Philadelphia: Westminster Press, 1966.

SATIR, Virginia. *Conjoint Family Therapy*. Palo Alto: Science and Behavior Books, 1967.

SATRE, Jean-Paul. *No Exit and the Flies*. New York: Knopf, 1954.

SCHILDER, Paul. *The Image and Appearance of the Human Body*. New York: Columbia University Press, 1942.

SCHOENBERG, B., *et al.*, (eds.) *Loss and Grief:* Psychological Management in Medical Practice. New York: Columbia University Press, 1970.

SCHONTZ, Franklin C. *Research Methods in Personality*. New York: Appleton-Century-Crofts, 1965.

SHOTLAND, E. D. *The Psychology of Hope*. San Francisco: Jossey-Bass, 1969.

SKINNER, B. F. *Cumulative Record*. New York: Appleton-Century-Crofts, 1952.

STROMMEN, Merton. *Research on Religious Development:* A Comprehensive Handbook. A Project of the Religious Education Association. New York: Hawthorn Books, 1971.

SULLIVAN, Harry Stack. *The Psychiatric Interview*. New York: Norton, 1954.

THORNTON, Edward E. *Theology and Pastoral Counseling*. Englewood Cliffs: Prentice-Hall, 1964.

TILLICH, Paul. *The Courage to Be*. New Haven: Yale University Press, 1952.

_____. *The New Being*. New York: Charles Scribner's Sons, 1955.

_____. *Dynamics of Faith*. New York: Harper & Bros., 1957.

_____. *The Eternal Now*. New York: Charles Scribner's Sons, 1963.

_____. *Shaking the Foundations*. New York: Charles Scribner's Sons, 1950.

_____. *Systematic Theology*. 3 vols. Chicago: University of Chicago Press, 1963.

_____. *Theology of Culture*. New York: Oxford University Press, 1959.

_____. *Ultimate Concern*. New York: Harper & Row, 1965.

_____. *What is Religion?* New York: Harper & Row, 1969.

WALKER, James L. *Body and Soul*. Nashville, N.Y.: Abingdon Press, 1971.

WEISMAN, Avery D. *The Existential Core of Psychoanalysis:* Reality, Sense and Responsibility. Boston: Little, Brown, 1965.

WHITE, Dale, (ed.) *Dialogue in Medicine and Theology*. Nashville: Abingdon Press, 1967, 1968.

WHITE, Robert W. *Lives in Progress*. New York: Holt, Rinehart and Winston, 1961.

WOODRUFF, C. Roy. *Alcoholism and Christian Experience*. Philadelphia: Westminster Press, 1968.

WRIGHT, Beatrice. *Physical Disability*--A Psychological Approach. New York: Harper & Row, 1960.

B. ARTICLES

ANDERSON, Camilla M. "The Pot and the Kettle," in O. Hobart Mowrer (ed.) *Morality and Mental Health*. Chicago: Rand McNally, 1967.

BLACK, H. R. "Psychoanalysis and Blindness," *Psychoanalytic Quarterly*, XXVI (1957), 1-23.

BRIERSDORF, Jack E., and John R. Johnson, Jr. "Religion and Physical Disability," *Rehabilitation Record*, VII:1 (January-February 1966), 1-4.

CANTRIL, Hadley. "A Fresh Look at the Human Design," in James F. T. Bugental, (ed.) *Challenges of Humanistic Psychology*. New York: McGraw-Hill, 1967.

CHRISTOPHERSON, Victor A. "Role Modification of the Handicapped Homemaker," *Rehabilitation Literature*, XXI:4 (April 1960).

CLINEBELL, Howard J., Jr. "Training Clergymen to Train Laymen for Caring and Social Action Ministries," *Exploration in Ministry*, an IDOC Dossier, IDOC, North America (1971), 57-67.

COHN, Nancy K. "Understanding the Process of Adjustment to Disability," *Journal of Rehabilitation*, XXVII (November-December 1961).

COMAR, A. Estin. "Marriage and Divorce Among Patients with Spinal Cord Injury," *Journal of Indiana Medical Profession*, IX:9 (December 1962).

DEMBO, Tamara, *et al*. "Acceptance of Loss-Amputations," *Psychological Aspects of Physical Disability*. Rehabilitation Services No. 210, Washington, Department of Health, Education and Welfare, Office of Vocational Rehabilitation, 1953.

DUNCAN, Franklin D. "Pastoral Care of Disabled Persons," in Wayne E. Oates and Andrew D. Lester, (eds.) *Pastoral Care in Crucial Human Situations*. Valley Forge: Judson Press, 1969.

FINK, Stephen L. "Crisis and Motivation: A Theoretical Model," *Archives of Physical Medicine and Rehabilitation,* XLVIII (November 1967).

FRIEDLAND, F. "Rehabilitation in Spinal Cord Injuries," in S. Licht, (ed.) *Rehabilitation and Medicine.* Baltimore: Waverly Press, 1968.

GOFFMAN, Erving. "The Characteristics of Total Institutions," in *Symposium on Preventive and Social Psychiatry.* Washington: Walter Reed Institute of Research, U. S. Government Publishing Office, 1958.

GREAVES, Mary. "Work and Disability," London: British Council for Rehabilitation of the Disabled, 1969.

GUTTMAN, L. "The Married Life of Paraplegics and Tetraplegics," *Paraplegia,* II (1964/5).

HAMBURG, D. A., and J. E. Adams, "A Perspective on Coping Behavior," *Archives of General Psychiatry,* XVII (September 1967).

HEINRICH, E., and L. Kriegel. "Experiments in Survival," New York: Association for the Aid of Crippled Children, 1962.

KAHN, Robert L., and Charles F. Cannell. "Interviewing" in Gardner Lindsey and Elliott Aronson, (eds.) *Handbook of Social Psychology.* Reading, MA: Addison-Wesley, 1968.

KIMBALL, C. P. "Conceptual Developments in Psychosomatic Medicine: 1939-1969," *Annals of Internal Medicine,* LXXIII (1970), 307-16.

KUTNER, Bernard, *et al.* "A Therapeutic Community in Rehabilitation Medicine," Research Committee Report, Albert Einstein College of Medicine of Yeshiva University, Bronx (July 1970).

MAHONEY, Florence I. "Rehabilitation of Spinal Cord Injured Patients," *Maryland State Medical Journal,* XVIII (October 1969).

MAISEL, E. "Meet a Body." New York: Institute for the Crippled and Disabled, 1953. (Manuscript.)

MARRA, Joseph L., and Fred Novis. "Family Problems in Rehabilitation," *Personnel and Guidance Journal,* XXXVIII:1 (September 1959).

MCEVER, Dan H. "Pastoral Care of the Spinal Cord Injury Patient," *Pastoral Psychology,* XXIII:221 (February 1972).

MEYERSON, L. "Somatopsychology of Physical Disability," in W. M. Cruickshank, (ed.) *Psychology of Exceptional Children and Youth.* Englewood Cliffs: Prentice-Hall, 1955.

MORRISEY, Alice B. "Psychological and Spiritual Factors in Rehabilitation," *American Journal of Nursing*, L:12 (December 1950).

MUELLER, Alfred D. "Psychological Factors in Rehabilitation of Paraplegic Patients," *Archives of Physical Medicine and Rehabilitation*, XLIII (April 1962), 151.

NADOLSKY, Julian M. "Diagnosis in Rehabilitation Counseling--An Existential Approach," *Rehabilitation Literature*, XXVII:3 (March 1966).

NEFF, Walter, and Samuel A. Weiss. "Psychological Aspects of Disability," in Benjamin B. Wolman, (ed.) *The Handbook of Clinical Psychology*. New York: McGraw, 1965.

Patient Handbook for the Regional Spinal Cord Injury Rehabilitation Center of Rancho Los Amigos Hospital, Downey, California. Los Angeles: Oxford Press, 1968.

PROELSS, E. Frederick. "Ministering to the Physically Disabled Person," *Pastoral Psychology*, XVI (June 1965), 8-22.

ROGERS, Carl R. "Two Divergent Trends," in Rollo May, (ed.) *Existential Psychology*. New York: Random House, 1961.

SCHONTZ, Franklin C. "Severe Chronic Illness," in James F. Garrett, and Edna S. Levine, (eds.) *Psychological Practices with the Physically Disabled*. New York: Columbia University Press, 1962.

SILLER, Jerome, and Abram Chipman. "Attitudes of the Non-Disabled Toward the Physically Disabled." (Final Report, V.R.A. Project, RD-707, May 1967.) New York: New York University School of Education, 1967.

SKIPPER, J. H., Jr., S. L. Fink, and Phyllis N. Hallenbeck. "Physical Disability among Married Women: Problems in the Husband-Wife Relationship," *Journal of Rehabilitation*, XXXIV:5 (1968).

STEIN, Edward V. "The Role of Clergy in Catastrophic Illness," *Journal of Pastoral Care*, XX (March 1966).

TALBOT, Henry S. "A Concept of Rehabilitation," *Rehabilitation Literature*, XXII:12 (December 1961), 358-364.

_____. "The Sexual Function in Paraplegia," *Journal of Urology*, LXXIII (1955).

TILLICH, Paul. "Existentialism, Psychotherapy and the Nature of Man," *Pastoral Psychology*, XI:105 (June 1960).

_____. "The Spiritual and Theological Foundation of Pastoral Care," *Clinical Education for the Pastoral Ministry* (Advisory Committee on Pastoral Education, 1958), 2.

_____. "Theology and Counseling," *Journal of Pastoral Care*, X:4 (Winter 1956), 193-200.

TUCK, Lea L. "Bladder and Bowel Retra," *American Journal of Nursing*, LXX:11 (November 1970).

VAN DUSEN, Wilson. "The Natural Depth in Man," in Carl R. Rogers, and Barry Stevens, (eds.) *Person to Person:* The Problem of Being Human. Walnut Creek, CA: Real People's Press, 1967.

WEBER, Doreen K., and Henry C. Wessman. "A Review of Sexual Function Following Spinal Cord Trauma," *Physical Therapy*, LI:3 (March 1971).

WEISSMAN, R., and B. Kutner. "Role Disorders in Extended Hospitalization," *Hospital Administration*, XII (1967), 52-59.

ZAKS, Wachs H. "Studies of Body Image in Men with Spinal Cord Injury," *Journal of Nervous Mental Disorders*, CXXXI (1960).

C. UNPUBLISHED MATERIALS

DANIEL, Wilson E. "Cultural and Societal Expectations and Attitudes *vis-à-vis* Irreversible Physical Disability." Unpublished Seminar Paper delivered to Casa Colina Rehabilitation Center, Pomona, California, February 1971.

_____. "Irreversible Physical Disability *vis-à-vis* Human Sexuality, Marriage and Family Life." Unpublished Seminar Paper delivered to Casa Colina Rehabilitation Center, Pomona, California, April 1971.

FELDMAN, Daniel J. "Beyond Disease." Unpublished Monograph, 1970.

HARRISON, Jack B. "Paul Tillich and Psychotherapy." Unpublished Th.D. Dissertation, School of Theology at Claremont, 1967.

KIMPER, Frank W. "Love in Personality Development." Lecture delivered to Foundations III Class, School of Theology at Claremont, March 2, 1967.

KIMPER, Frank W. "Self and Therapy." Unpublished Seminar Paper delivered to Claremont Area Pastoral Counseling Center, Spring 1968.

SLACK, Sam L. "An Understanding of Drug Abuse from an Onto-Theological Concept of Man as Illustrated by Interview Studies of Compulsive Drug Abusers from Crisis House." Unpublished Th.D. Dissertation, School of Theology at Claremont, 1972.

ZELLER, Harry K. Unpublished Notes from a lecture given at Casa Colina Rehabilitation Center, Pomona, California, February 1970.

APPENDICES

APPENDIX A

INTERVIEW QUESTIONNAIRE

Code_____
Date_____
Male____ Female___
Married__ Single___
Children____ No.___

SELF-CONCEPT (IDENTITY) CATEGORIES

Category S.C. (1) *Stable, Intact Identity in tension with Identity Diffusion*

Question: Speaking as a person with irreversible physical disability, please respond in any way you wish to the question: "Who is . . . . . (interviewee's name)?" In other words, how would you answer the question: "Who am I . . . here and now?"

Category S.C. (2) *Anxiety in tension with Relaxation*

Question: Would you describe yourself as more relaxed since your acceptance of your injury or are you more anxious?

Category S.C. (3) *Mistrust in tension with Trustfulness*

Question: Do you consider you are more wary of people in general since your injury or have you become more trustful?

Category S.C. (4) *Depression in tension with Elation*

Question: Would you describe yourself as being more depressed since your injury or would you say you were more elated--happier?

Category S.C. (5) *Desire for Distance in tension with Desire for Closeness*

Question: As a result of your disability do you feel you wish to be more removed from people than previously or do you wish you were closer to others than before?

Category S.C. (6) *Freedom in tension with Bondage*

Question: Are there any ways in which you see yourself as more free right now than before your accident, or do you see yourself as more bound (restricted)?

Category S.C. (7) *Self-Responsible Attitude in tension with a Blaming Attitude*

Question: Who, if anyone, is responsible for where you find yourself, right now?

Category S.C. (8) *Personal Goals: Change vis-a-vis No Change*

Question: As a person with a permanent disability, have you made any changes in your personal goals?

Category S.C. (9) *Growth Motivation: The Push of Pain in tension with the Pull of Growth*

Question: At this moment what is the driving force behind your urge for your own self-development? Does it come more from a desire to escape from a painful situation, or do you strive to fulfill the dream of the type of person you wish to become, whose image you carry around inside you?

Category S.C. (10) *Cultivation of Inner Resources in tension with Total Reliance on External Resources*

Question: Where do you seem to be concentrating your energies nowadays--in building your own inner resources increasingly or in looking for help beyond yourself?

LIFE-STYLE CATEGORIES

Category L.S. (1) *Changes in State of Physical Health*

Question: What do you consider to be the most significant changes in your physical condition since you became a "wheelchair" person?

Category L.S. (2) *Changes in Personal and/or Domestic (Household) Maintenance Tasks*

Question: What changes have there been in the tasks necessary for the care of your own person and home?

Category L.S. (3) *Changes in Social or Recreational Activities*

Question: To what extent, if any, have you needed to change your social or recreational life since your injury?

Category L.S. (4) *Changes in Employment/Vocation Orientation*

Question: Has your injury obliged you to consider any other occupation for a living?

Category L.S. (5) *Changes in Parental (Child-Rearing Related) Activities*

Question: Has your behavior towards your children changed in any respect since your injury?

Category L.S. (6) *Changes in Sexual Behavior*

Question: What changes in your sexual behavior (and in your relationships with persons of the opposite sex) have occurred as a result of your injury?

Category L.S. (7) *Changes in the Marital Relationship*

Question: Have any changes and adjustments been necessary in your marriage?

Category L.S. (8) *Changes in Values and Social Attitudes*

Question: Have you observed any changes in your personal values and in social attitudes following your disability?

Category L.S. (9) *Changes in Religious Attitudes and Expression*

Question: What effects has your injury produced on your religious belief and life?

Category L.S. (10) *Changes in Utilization of External Resources*

Question: To whom have you looked for encouragement, support and assistance since your injury?
(Secondary Question: Is this different from before?)

Category L.S. (11) *Changes in Behavior Orientation: Reality vis-a-vis Avoidance*

Question: Has your behavior become directed more towards reality or more towards avoidance following your disability?

APPENDIX B

Code #_____

RELIGIOUS INVENTORY Date _____

A. The following items deal with various types of religious ideas and social opinions. I should like to find out how common they are. Please use the list below to indicate how you feel about each statement by writing the number corresponding to your choice in the blank next to each item. If none of the choices expresses exactly how you feel, then indicate the one which is closest to your own views. If no choice is possible, you may omit the item. There are no "right" or "wrong" choices. There will be many religious persons who will agree with all the statements.

A--Definitely agree
B--Tend to agree
C--Neither agree nor disagree
D--Tend to disagree
E--Definitely disagree

___1. When I have trouble, all I have to do is pray to God, who loves me, and He will help.
(Statements 2 through 30 follow in sequence as below)

SAMPLE RESULTS (8 Subjects)

STATEMENT	A	B	C	D	E
1) When I have trouble, all I have to do is pray to God, who loves me, and He will help.	1		3	4	
2) Heaven is my home, so I don't worry about this world.	1		1	2	4
3) There is goodness in man, even in the worst of us, which is put there by God and cannot be destroyed.	2	3	1	2	
4) It is important to me to spend periods of time in private religious thought and meditation.	3	2	1		2
5) If a person wants to serve God, let him or her serve mankind.	4	3	1		

STATEMENT	A	B	C	D	E
6) We are all part of each other because God's love for us is bound up in His love for others.	1	2	4		1
7) My religious beliefs are what really lie behind my whole approach to life.	2	1	1	1	3
8) The important thing in religion to me is the knowledge that God loves me like a father loves his children.	2		1	2	3
9) Nobody in the world is really good, least of all am I.	1			2	5
10) All of us are sinners and not worth very much.	1				7
11) The primary purpose of prayer is to gain relief and protection.		3	1		4
12) The way the world can be changed is for each person to know that God loves him.		1	5	2	
13) It is love and not wrath that is the essence of the nature of God.	3	2	1	1	1
14) Whatever God's punishment for me, I have no doubt that I deserve it.			2	1	5
15) The greatest sin is man's sin against his fellow man.	2	5			1
16) The main thing that Jesus of Nazareth taught was that God loves the individual human being just as he is.	2	4	1	1	
17) Among man's basic needs is the need to love and be loved (i.e. to affirm others and be affirmed in return).	7	1			
18) If I died today I would feel my life had been worthwhile.	4	2		1	1

STATEMENT	A	B	C	D	E
19) I believe there is a God.	4	1	2	1	
20) The fear of death is increasingly a real part of my experience.		1		3	4
21) If I had a choice, I would choose to live the same life again rather than a different one.		4	2		2
22) Up to this point in time, my life is still incomplete.	5	3			
23) All I seem to be doing in life is "treading water."	1	1	1	4	1
24) So far, my life has gone pretty much as I planned.			1	1	6
25) Looking back over my life it feels good to have been the person I am.	2	5		1	
26) My present life-style does not reflect what I have been in the past.	1	2		5	
27) I am very religious (more than most people).	2	1	1	2	2
28) No one cares much what happens to me.			2	2	4
29) No external circumstances can change my attitude to life; only I can do that.	3	2	1	2	
30) I believe my sins are unpardonable.			1	1	6

B. Please circle the letter of your choice which most nearly describes your answer to the following:

Which of the following most closely approximates your present theological position?

a. fundamentalist (1) b. liberal (1) c. neo-orthodox
d. God is dead. e. conservative (2) f. agnostic (2)
g. existentialist (2) h. atheistic.

APPENDIX C

Code #_____

Date _____

VALUES QUESTIONNAIRE

Select one of the two statements at either end of the scale that best describes you at this time. Then place a check mark in one of the four boxes that most accurately describes how true that statement is about you. Do not mark any of the four boxes for the opposite statement. Only one of the eight boxes on each line should be marked. Please do not omit any scale.

	COLUMN II	COLUMN I
1.	I am not yet certain how I feel about the ethical and social problems most important to me.	I am certain about how I feel about the ethical and social problems most important to me.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
2.	I often so act on impulse that my behavior contradicts what I value and believe.	I seldom so act on impulse that my behavior contradicts what I value and believe.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
3.	It is not important to me to consider how my behavior will affect other people before I act.	It is important to me that I consider how my behavior will affect other people before I act.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
4.	I sometimes take unexpected positions about issues just to assert my independence of my family and friends.	I do not take unexpected positions about issues just to assert my independence of my family and friends.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true

Code # _____

Date _____

	COLUMN II	COLUMN I
5.	I usually can readily explain what I believe what I do about an issue.	I frequently cannot explain very well why I believe what I do about an issue.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
6.	People who know me very often cannot predict the opinion I will have about an issue.	People who know me usually can predict quite well the opinion I will have about an issue.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
7.	I cannot accomplish my more important goals and still do many other things I would really like to do.	I can accomplish my more important goals and still do many other things I would really like to do.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
8.	I frequently cannot understand why others do not believe and value the same things I do.	I usually can understand why the beliefs and values of others are different from mine.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true
9.	I frequently do not do what I want to do because of what my family and friends would think.	I do what I want to do despite what my family and friends think.
	8 7 6 5	4 3 2 1
	Very true Moderately Slightly	Slightly Moderately Very true

Code # _____

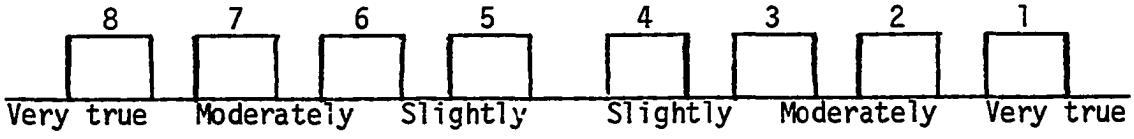
Date _____

COLUMN II	COLUMN I
10. I would find it very difficult to describe my values and beliefs.	I would find it easy to describe my values and beliefs.
8 7 6 5	4 3 2 1
Very true Moderately Slightly	Slightly Moderately Very true
11. For many years my life has not been guided by any fundamental attitudes and convictions that have given meaning to my life.	For many years my life has been guided by a few fundamental attitudes or convictions that have given meaning to my life.
8 7 6 5	4 3 2 1
Very true Moderately Slightly	Slightly Moderately Very true
12. Even though I may be very inconsistent and contradictory in my values and behavior, I have no strong desire to make them more consistent.	If I am inconsistent and contradictory in my values and behavior, I am not content until I find a way to make them more consistent.
8 7 6 5	4 3 2 1
Very true Moderately Slightly	Slightly Moderately Very true
13. I am not really sure what other people think of my goals and values.	I usually know what other people think of my goals and values.
8 7 6 5	4 3 2 1
Very true Moderately Slightly	Slightly Moderately Very true
14. What I value and believe are frequently influenced by my immediate desires and impulses.	What I value and believe are seldom influenced by my immediate desires and impulses.
8 7 6 5	4 3 2 1
Very true Moderately Slightly	Slightly Moderately Very true

Code # _____

Date _____

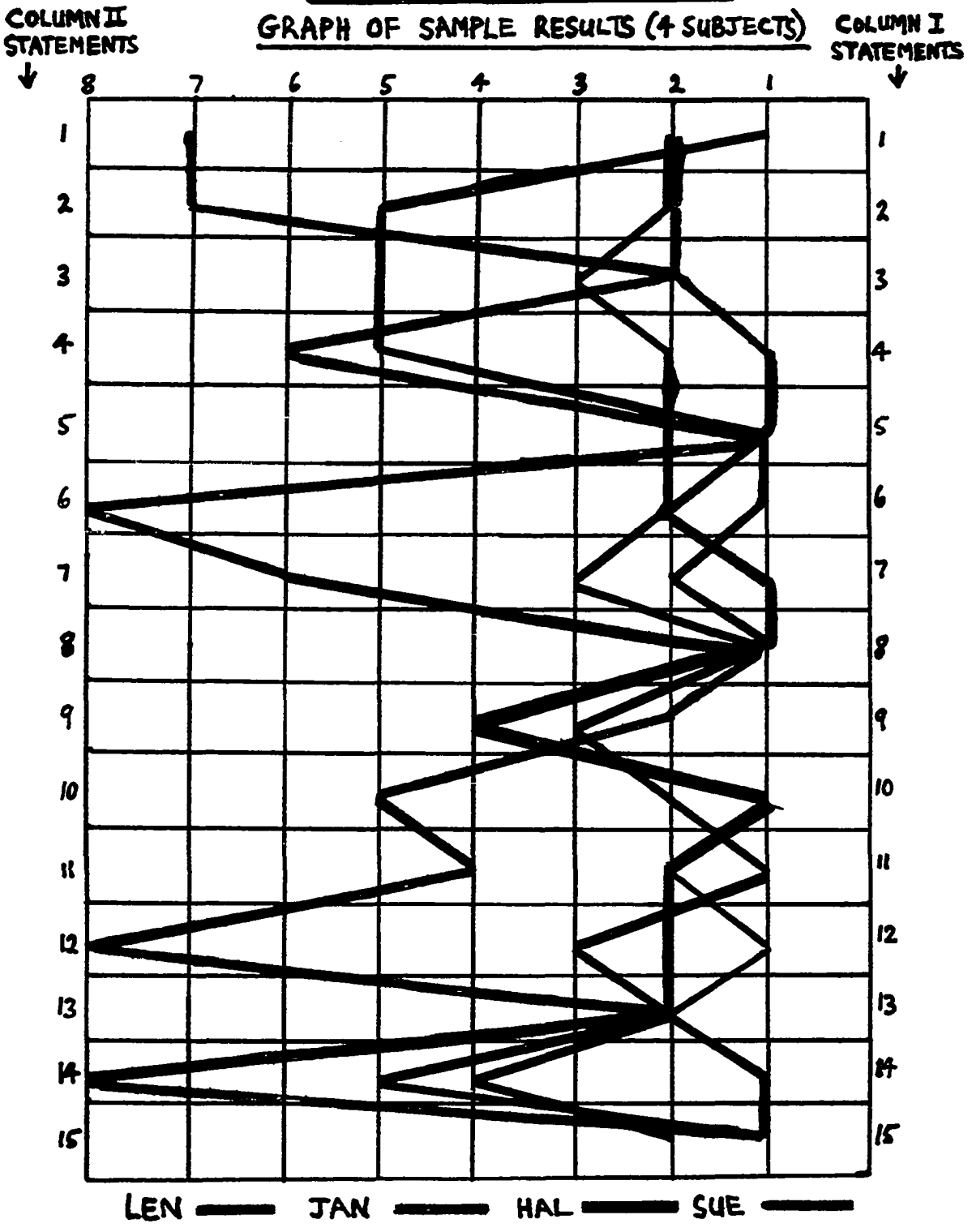
	COLUMN II	COLUMN I
15.	I do not really understand why I have been unable to achieve some of my goals.	I understand quite well why I have not been able to reach some of my goals.



APPENDIX C (continued)

VALUES QUESTIONNAIRE

GRAPH OF SAMPLE RESULTS (4 SUBJECTS)



APPENDIX D

Code # _____

Date _____

SELF-INSIGHT QUESTIONNAIRE

Instructions for Self-Rating

Rate as accurately as you can the degree to which you possess one of each pair of traits on the enclosed sheets. For ratings on this scale, 1 = extreme on the left side, 8 = extreme on right side. If, for example, you judge yourself to be a cheerful person, you would check box #1 for the sample item below. Or if you think you are moderately depressed much of the time, you might check either box #6 or #7. Check *only one* of the 8 boxes for each pair of traits. Try to describe yourself as accurately as you can. Work rapidly. Please do not omit any items.

Special Trait:

Depressed				Cheerful			
☐	☐	☐	☐	☐	☐	☐	☐
8	7	6	5	4	3	2	1
Very	Moderately		Mildly	Mildly		Moderately	Very

Code # _____

Relationship to person rated: (e.g. spouse, friend, professional staff member, etc.)

_____

Date _____

Instructions for Rating Others

Please rate as accurately as you can the degree to which _____ possesses one of each of the pair of traits listed on the enclosed sheets. For ratings on this scale, 1 = extreme on left side, 8 = extreme on right side. If, for example, you believe that the above named person is a very cheerful person, compared to other persons of his age, then, you would place a check in box #1. Or if you think that he is a moderately depressed person, then you might check either #6 or #7. Try to describe as accurately as you can this person. Check only one of the 8 boxes for each pair of traits. Please work rapidly as your first impressions are frequently more valid ones on rating scales like this one. Do not omit any items.

Code # _____

Date _____

Special Trait:

Depressed							Cheerful
8	7	6	5	4	3	2	1
Very	Moderately	Mildly		Mildly	Moderately		Very

1. Subjective
Prefers to base judgments on his feelings and intuition; his judgments are more appreciative and emotional than critical or logical; tender-minded.

Objective
Prefers to base judgments on facts rather than on his own feelings and wishes; is rational and critical; tough-minded.

8 7 6 5 4 3 2 1

2. Rejects self
Critical of himself; does not accept some of his own traits or motives but would like to be a different kind of person; uncomfortable about some of his feelings and desires.

Accepts self
Recognizes but accepts his limitations and mistakes as well as his good qualities; is reasonably satisfied with the kind of person he is; respects himself.

8 7 6 5 4 3 2 1

3. Self-involvement
Very serious about himself; unable to laugh or joke about himself and his mistakes; preoccupied by his own problems and desires; may not have sense of humor.

Self-perspective
Can be objective and detached about himself; accepts his mistakes with humor; able to laugh at himself.

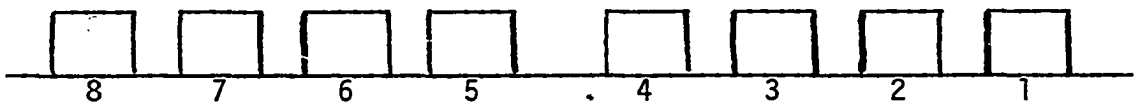
8 7 6 5 4 3 2 1

Code # _____

Date _____

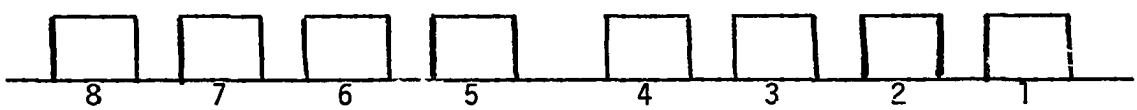
4. Defensive
Secretive, keeps thoughts and feelings to himself; does not like to talk about his feelings and problems with anyone else; tries to appear he is a different person than he is; may evade questions or approaches of other people.

Open
Forthright, spontaneous, frank and direct in his expression; does not try to appear different than he is or try to protect himself when with others; easily expresses his own feelings.



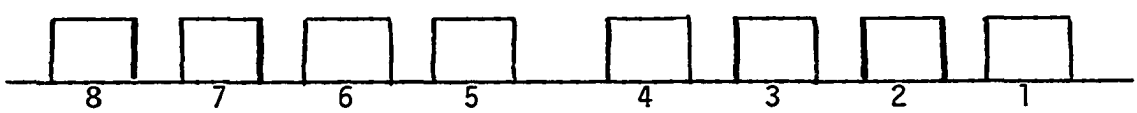
5. Suspicious
Frequently believes other people are unfair or dislike him; distrusts motives of others; may believe others talk about him when in fact they are not; hard to convince.

Trustful
Generally accepts actions and comments of others without distrusting their motives towards him; does not believe most other people want to take advantage of him.



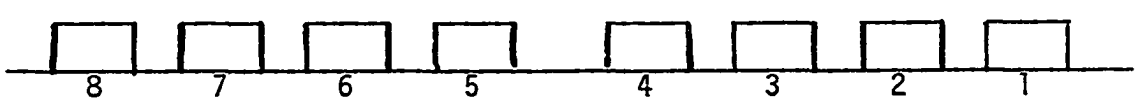
6. Apathetic
Lacks drive, energy, vitality; appears to be passive, without strong interests.

Energetic
Has unlimited energy, high drive, vitality; needs to be constantly active; interested in many activities.



7. Rigid
Strongly maintains his own ideas against all opposition; resists changing or adapting to new ways of doing things; does not like to change his habits or way of life.

Flexible
Adapts his behavior when necessary to new situations; can compromise; is not surprised, baffled, or irritated if things are different from what he expected.

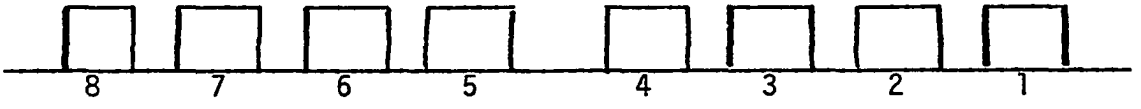


Code # _____

Date _____

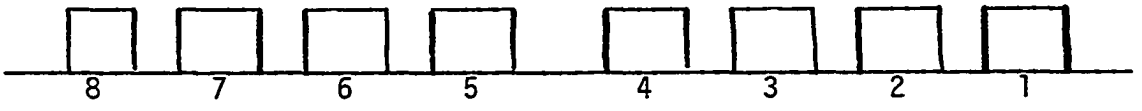
8. Demanding
Demands much of himself and of others; drives and pushes himself; very determined person.

Easy going
Does not demand much of himself or of others; seems to have time to do whatever he wants to do at the moment; leisurely.



9. Disordered
Behavior is disorganized, unplanned, erratic; does not like to schedule or make plans; usually unprepared for the next few days or weeks.

Ordered
Behavior is scheduled, planned, regulated; knows what he is going to do for the next few weeks; usually prepared.

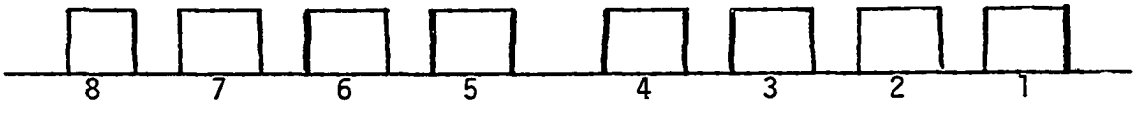


10. Easily upset
Easily becomes confused, excited, or embarrassed in new situations or emergencies; may readily blush or become tense and anxious.

Unshakable
Does not lose self control in emotional or emergency situations; is slow to anger; self-possessed.

11. Stubborn
Acts as though his viewpoint is right and others' wrong; adamant, unyielding in opinion, aggressively persistent

Compliant
Uncertain of own ideas, beliefs, opinion; submissive to will, guidance or control of others, obedient.



Code # _____

Date _____

12. Impulsive
Earthy person; expresses needs without inhibition, has to have desires satisfied immediately; very changeable, moody; unable to tolerate much frustration; uncontrolled and disorganized.

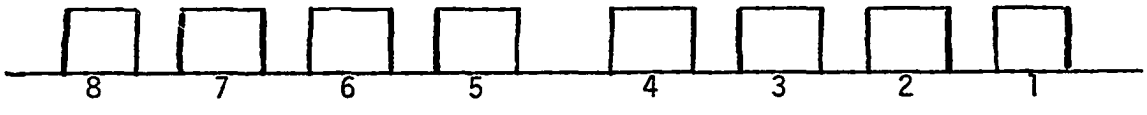
Self-Disciplined
Tends to restrain impulses, often postpones immediate satisfactions for greater future goals or contentment; tolerates frustrations well, consistent, controlled and persevering.

13. Unenthusiastic
Does not get emotionally involved or excited; may be difficult to motivate or to excite; unexpressive, mild, not much excites him.

Enthusiastic
Emotionally responsive, interested and excited about new events; gets involved in activities easily; has strong interests which excite him.

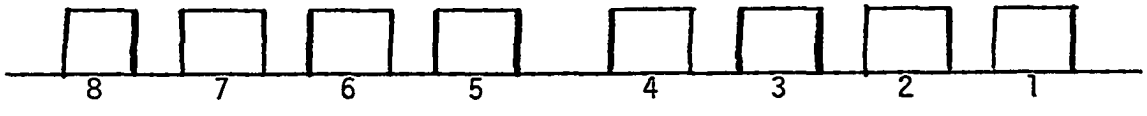
14. Unimaginative
Thinking is conventional, obvious, literal, matter-of-fact; not interested in complexities of a problem that are not immediately relevant to its solution.

Imaginative
Has a rich and vivid imagination; thinks of unusual aspects of problems; imagines many more possibilities and alternatives than other people imagine.



15. Unpredictable
Moods and behavior are inconsistent, changing and unpredictable; surprises other people with what he says or does.

Predictable
Moods and behavior are generally similar and consistent from day to day.

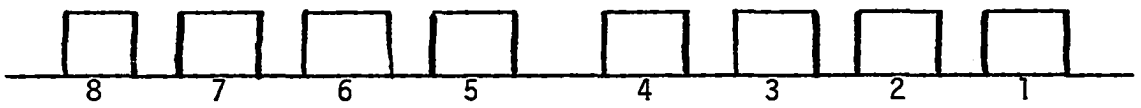


Code # _____

Date _____

16. Aggressive
Critical of others; rebellious, assertive.

Gentle
Uncritical of others; peaceable, mild.



17. Domineering
Arrogant, overbearing, lords it over others, condescending, gives orders, demands obedience from others.

Submissive
Seldom asserts own will, submits to demands from others, unaggressive, wants order, rarely asserts his own will.

18. Unreflective
Prefers not to question why but to live life as it occurs; does not enjoy thinking about his experiences; accepts facts for what they are.

Reflective
Enjoys thinking and reflecting about his experiences, the motives of others, or social problems; seeks to understand why the facts are what they are; inner depth.

19. Dependent
Needs the advice and help of others; seeks guidance readily; suggestible; not self-sufficient; cannot deny requests of other people whose affection and respect he wants.

Independent
Does not like to depend on others; seldom asks for advice; prefers to rely on his own efforts; may maintain own way of life in face of considerable opposition; can say no to requests.

Code # _____

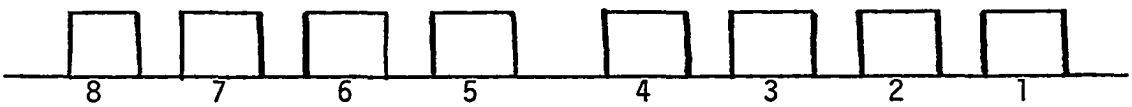
Date _____

20. Cautious
Avoids strange and new situations; prefers to know everything about a situation before acting; does not take risks.

Adventurous
Seeks new and strange experiences; shows much initiative; enjoys risks and uncertainty.

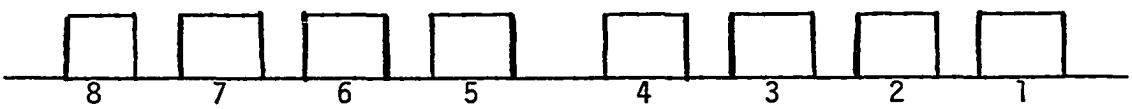
21. Unrealistic
Makes impractical, inappropriate suggestions that don't consider all aspects of a problem; other people do not rely on his judgments.

Realistic
Has good judgment and common sense; makes practical and appropriate comments and decisions.



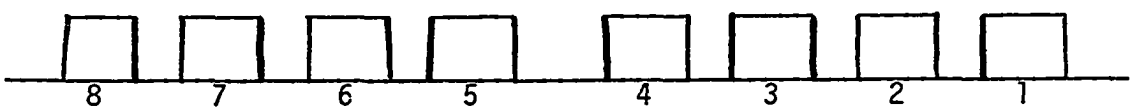
22. Purposeless
Life has no direction of meaning; seems to be without purpose; flighty, distractable; does not know what he wants.

Purposeful
Life has personal direction and meaning; behavior is planful, persistent and determined; energies are concentrated on a limited number of activities.



23. Indecisive
Does not like to make decisions; must know all possibilities before acts; hesitates a long time before making decisions; doubting.

Decisive
Makes decisions with firmness; enjoys making decisions and fulfilling them.

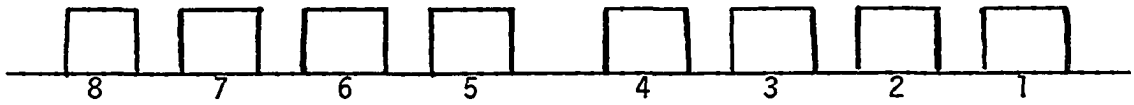


Code # _____

Date _____

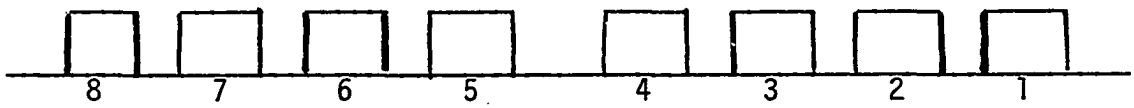
24. Not anticipate consequences
Impulsively acts without thinking of the consequences; frequently makes mistakes because he has not anticipated the possible outcomes.

Anticipates consequences
Considers future possibilities and consequences of his decisions before acting; foresighted.



25. Weak convictions
Few, if any, convictions or ideals that strongly influence his life; feels life is "empty," without meaning or value; may wish he had stronger beliefs and convictions.

Strong convictions
Dedicated to some value or ideal; motivated by strong beliefs and values (either religious, ethical, political, social).



26. Rejects own limitations
Continually critical of himself and his limitations; constantly fears failure; assumes he must be perfect so as to be acceptable to others; therefore, afraid to take risks; afraid of his own desires and feelings.

Accepts own limitations
Accepts his limitations and mistakes besides recognizing potentials and good qualities; willing to try; although expresses tension between what might be done and what he can do, still not overcome by conflict; ready to take risks for self-improvement.

Code # _____

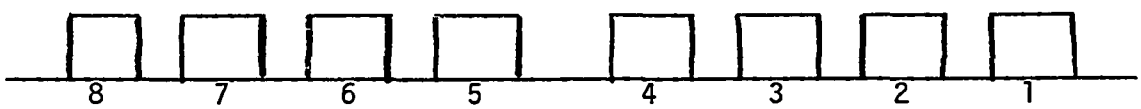
Date _____

27. Low aspirations
Unambitious and sets low goals for himself; easily satisfied with what he accomplishes; not unhappy if does not accomplish very much.

High aspirations
Ambitious and has strong need to achieve; sets high goals for self and often dissatisfied when he does not accomplish all of them; when completes a task, begins another immediately.

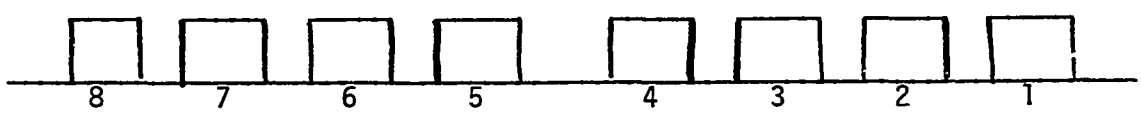
28. Not fulfilling his potential
Could accomplish more than what he is; others say he has talents that he does not use or is not developing; feels blocked and unable to use all his talents.

Fulfilling his potential
He is fulfilling his native capacities; satisfied he is accomplishing what he is capable of doing; does not feel blocked by inhibitions.



29. Self-centered
Thinks more about himself and what he wants than about other people; talks a great deal about himself; frequently ignores the rights and needs of other people; opportunistic; egoistic.

Other person-centered
Thinks of others and what they want; tries to consider points of view of other persons; can compromise; may attempt to adjust to demands of others; altruistic, considerate.



Code # _____

Date _____

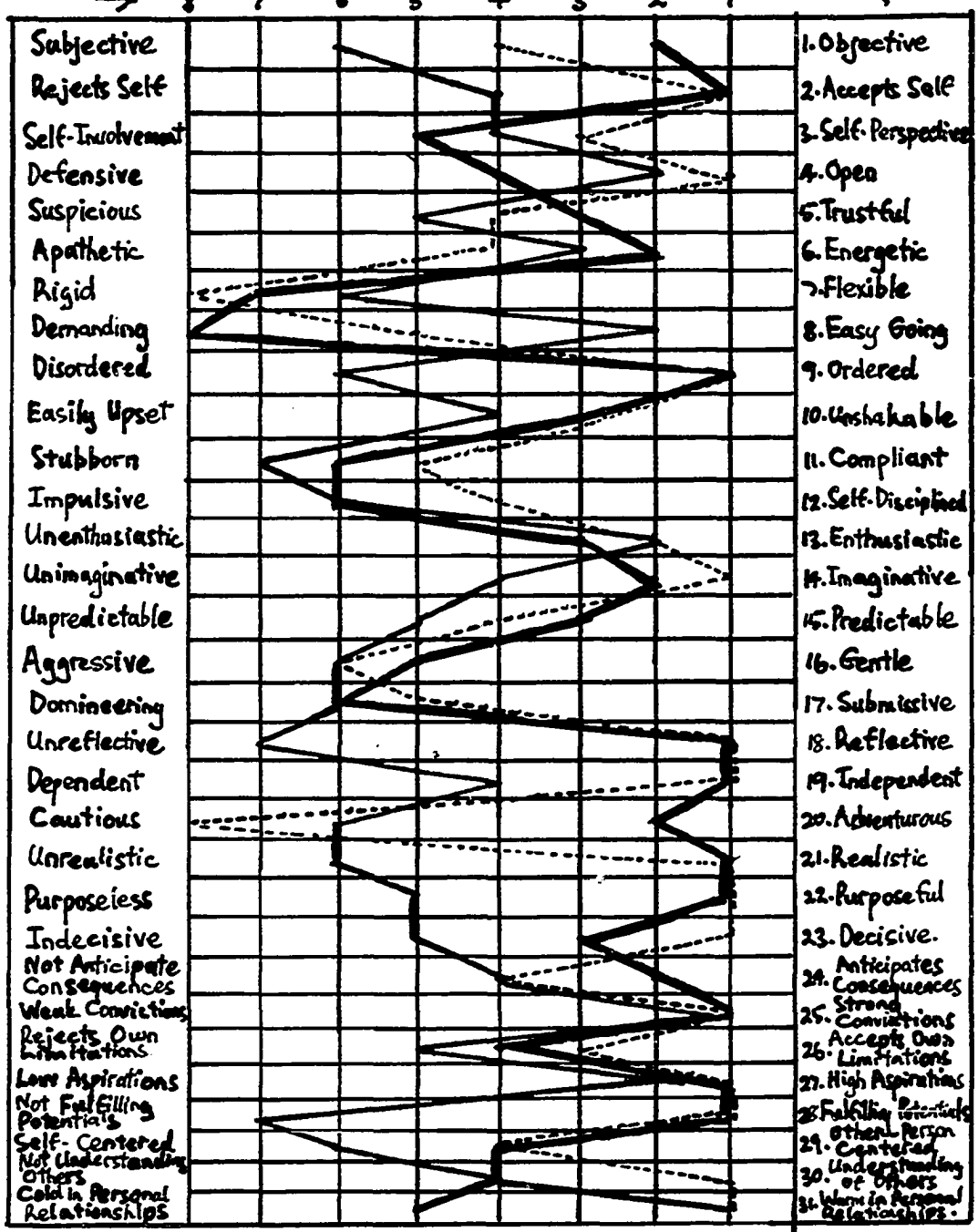
30. Not understanding of others
Not aware of or interested in the feelings and problems of others; may be tactless and brusque; other persons may say he doesn't "understand" and do not go to him for advice.

Understanding of others
Sympathetic, empathic, insightful about the feelings and problems of other persons; a person to whom others go for advice when in trouble.

31. Cold in personal relationships
Aloof, austere, and undemonstrative with others; does not like to express affection or sentiment; may be more comfortable in impersonal relationships.

Warm in personal relationships
Sincerely friendly, emotionally responsive, sympathetic to others; affectionate; may be demonstrative; enjoys other people.

Self-Insight Questionnaire.

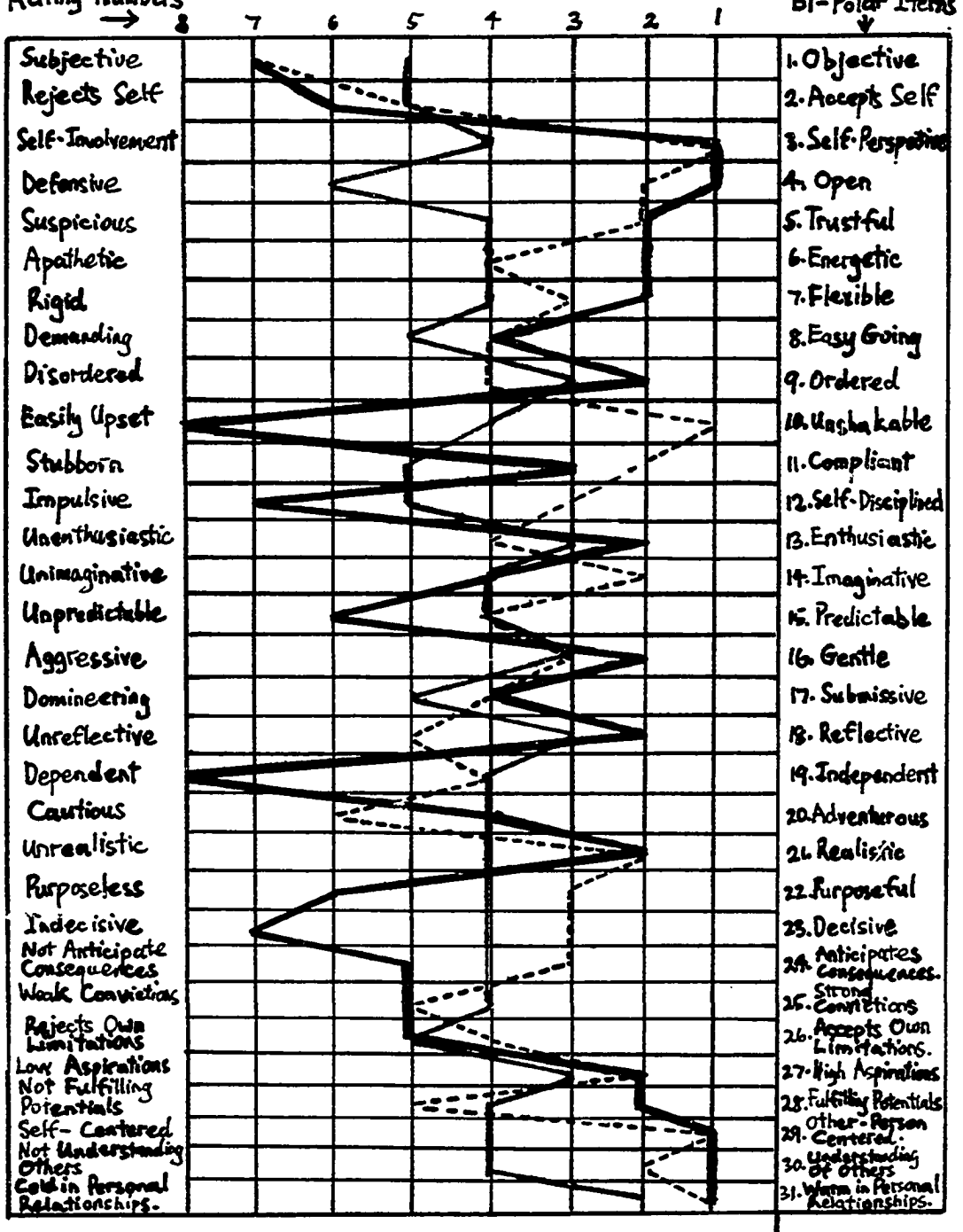


RATING TOTALS								
Self ▬▬	1	1	3	3	4	5	5	9
Significant Others------	2		1	3	7	3	1	14
(Husband, Wife, Friend) Staff (Professionals)	3	9	5	7	1	4	2	

NAME

Len.

Self-Insight Questionnaire



RATING TOTALS

Self ———	2	3	3	3	3	1	10	4
Significant Other ------ (Husband, Wife, Friend)	1	1	4	8	6	7	4	
Staff (Professionals)		1	7	17	5	1		

NAME

Jan